Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** PRIL 2009 Catherine Elizabeth Ratajczak /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RIEN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09/21/1918 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. Months 1 □ M 2Å F 90 Maryland 219-28-9509 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State show n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov raumatic event, tre Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Director Maryland | Harford Forest Hill 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 2543 Johnson Mill Road 21050 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store 8 Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland and 2 should be Martha Bowers Frederick Panzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trains once. 803 Sidehill Drive Bel Air, Maryland 21015 Kathleen Weber - Granddaughter 20b. Place of Disposition (Name of cemetery crematory of other place)
Saint Stanislaus
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/16/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturum Funeral Service Licensee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA END STAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 🛣 No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown HYPERTENSION. has been signed 2 should b MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COROWARY ARTERY page performed? Yes 2 2 No certificate 2 □No 1 ☐ Yes 1 ☐ Yes After this certification, funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? or Attending 1 Natural 2 Accident 5 ☐ Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

o Records, of Vital Division To the Hospital

> 622 S, 4MON SYRESH DHANJANI 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 0 2009 Registrar

Muzale

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

29b. Signature and title of certifier

park

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 4 **Physician** RIGGS VANGELINE HORI /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL HOSDITAL 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F Year) 007-18-1707 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show Examiner must be notifled at North 1 ☐Yes 2 No **Funeral Director** 10e. Street and Number 10g, Citizen of What Country? ö 23a Pages 1 and 2 should be filed within 72 hours after death Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If them 27 Is marked other than " any injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4or 5+) GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type. Print) JOSE 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HANOVER. 21. Signatury of Funeral Service Licensee homes 254 WESTMINSTER, MD 21157 ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 horri MESSIVE /Medical Due to (or as a consequence of) Examiner Lyδως hijtory

Due to (or as a consequence of): Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📈 No Month 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 **2** No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 10 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20055190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital 106 Bow St EIKton MD 2/92/ 417 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend Item 20b per fn g890 4-20-09 vt
State of Maryland / Department of Health and Mental Hygiene []

12503 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRTL 16 2009 2:00P M Physician CARLEEN RIFKIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
JULY 5 1935 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 M 2 F Months Hours MARYLAND 73 218-30-5854 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examir at most be rectified at 1 X Yes 2 □ No Director N/A BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6711 PARK HEIGHTS AVE # L-3 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1∐Yes 2∐XNo If Yes, Give Year or Dates: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **TAPPER** MARY GOLDMAN HENRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 PARK HEIGHTS AVE. #L-3, BALTIMORE, MD 19a. Informant's Name/Relationship (Type. Print) 21215 MARK RIFKIN/SON Method of Disposition

↑□ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 17/2009 12009-BALTIMORE, MD HEBREW YOUNG MEN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mail Cee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MONTHS **Physician** END-STAGE RENAL DISEASE resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and -transit Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ISLHEMIC CARDIDMUDPATHY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a. Was an has autopsy performed? 1 ☐ Yes 2 **X**No COPONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cother (Specify) HOSPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Division of 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No completely filled in by the 24 hours after dead Puneral director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the | within 2 To the |

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifier

DANIEUE

DOBERMAN, MD ESTAS N CHAPLES ST, SUITE 209 BALTMORE, MD 2124 32. Pogištrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 0

P

29c. License number

29d. Date signed (Month, Day, Year)

D64395 APRIL 16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:47 P M 2009 George Seeds III 15 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Hospice Baltimore 8. Date of Birth (Month, Day, Yea 6/11/1949 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Hours Min. 1 X M 2 T F Baltimore 59 Director 215-56-5205 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantines... Baltimore Essex 1 ☐Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21221 U.S.A 1042 Middlesex Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 KNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □Yes 2 XNo Specify: þ 3 Widowed 4 X Divorced 2 should be filed within 72 hours nand Mental Hygiene.

Is marked other than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Ransone Mary Seeds George ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Seeds IV/ Son Tack Court, Essex, MD 21221 George 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/16/2009 Anatomy Gifts Registry Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 1)(5 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician END STAGE RENAL DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 X No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

7:47

2009

law requires that the death certificate be executed After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: A filled in by

GEORGE SEEDS

Division

5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical

29a. Certifier	1 CertifyIng Physician: To the best of my knowledge, death occ	surred at the time, date and place, and due to the	ne cause(s) and manner as stated.					
(Check only								
one)X Nu	One)X Nurse Practitioner er stated.							
20h Cianatura and	7	29c License number	29d. Date signed (Month, Day, Year)					

4/16/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKTE JONES, 31. Date filed (Month, Day, Year) CRNP

State Registrar

completely

To the

APR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 20 Day 2009 Year **Physician** Strassburg 4:00 A M Anita /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sunrise Assisted Living of Columbia Columbia Howard 8. Date of Birth (Month, Day, Year) February 7, 1919 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Months Days Hours 1 □ M 2 🐴 F 125-05-5959 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filled within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinating the retiffical at Director Maryland Columbia 1 ☐ Yes 2 ☑ No Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A. 6316 Raritan Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐Yes 2 📉 No Black, White, etc 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2√√No Specify 2 Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Wohl Harry Silberman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Daughter) 6316 Raritan Court Columbia, Maryland 21045 Harriet R. McMahon Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Atlantic Crematory 4-21-2009 Glen Burnie, Maryland 4 ☐ Donaţion 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lic 22 Name and Address of Facility
Witzke Funeral Homes, Inc. - MO 1283 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final **Physician** Alzheimers Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy performed?

1 □ Yes 2 ☑ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted examiner' Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Living _2**X** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D. D56531 April 20, 2009 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 8600 Snowden River Parkway #301 Columbia, Maryland 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			Type or Print in B State of Maryland						•	
		1 - For State Registrar			tificate of l			Reg. No	0000	12506
Physic /Med		1. Decedent's Name (First, Middle, Las Martina	,	5	imms		2. Date of D Month April	OL	f 2009	3. Time of Death 17: 28 M
Exam		4a. Facility Name (If not institution, give			4b. City, Town, o Baltimore		th .	40	c. County of Dea	th
Funeral Director		220-33-5284	ex 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mir		Day, Year)	9. Bir	thplace (State or Foreign untry) MD
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD		Town or Lo						10d. Inside City Limits
with the	Director	10e. Street and Number			10f. Zip-Code				tizen of What Co	ountry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	2401 LOYOLA NORTH 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	IWAY - APT #302 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. \	21215 Vas Decedent of F f Yes, specify Cuba □ Yes 2X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	USA °-	14. Race - Ame Black, Whit	
215-0036 thin 72 hours aft e. an "natural", or Medical Examir	Completed	15. Decedent's Ec (Specify only highest grant Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b.	Kind of Business	/Industry
d 21 filed wif Hygien ther the		10TH 17. Father's Name (First, Middle, Last)		CRE	€W	18. Mother's N	ame (First, Midd		FAST FO	DD
Maryland to 2 should be flighth and Mental Hy 27 is marked oth traumatic event.	To Be	NATHANIEL W. SIMM	1S			ANTONIA			,	
Mary 12 sho h and h 7 is ma trauma		19a. Informant's Name/Relationship (7			ng Address (Street					Zip Code)
Baltimore, I sermit. Pages 1 and Department of Healt mportant: If item 2 any injury or other once.		ANTONIA SIMMS/MOT 20a. Method of Disposition 1 Burial 2 **Cremation 3 **Description** 4 Donation 5 Other (Specify	Removal from State 20b. Pla	ce of Disponetery, cren	Sition (Name of natory or other place	ce)	Date	20c. L	21206 ocation - City or	
Baltir permit. F Departme Importan any injur		21. Signature of Funeral Service Licens		ARDI 22	2007–09	ss of Facility WI		AVIS	, JR. FI	NRL. HM.
Physician /Medical		23a. Pal 1. Enter the dis ray or comp shock, or heart fail to List only of Immediate Cause (Final disease or condition resulting in death)	a Pneumomed	iast	er the mode of dyi	ng, such as cardi	ac or respiratory	arrest,	•	Approximate Interval Between Onset and Death 5 days
Examiner	Jer		b. Idio athic Due to (or as a conseque	Pheu	monia	Syndre	me'			30 days
60, be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Bone Marrou Due to (or as a conseque	nce of):	,				Ų	17 weeks
	edical		d Bcell lympha	blas	tic lyn	nphoma				41 months
I Records, P.O. Box 687(The law requires that the death certificate the has been signed by the attending priysing egge 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3	Ectopic pregnanc Other (specify)	y .		_	23d. Date of de Month	livery Day Year
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of Vital Physician: T this certificate and director, pa	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2/Outnotion	t 3 DOA Oth	or:	eath (Check only		0 0 0 0 0 0	-43
on of lng Phys (ther this funeral d	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	f 28c. Injur Wor	y at k?	Home 5 Res			city)
Division or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	1	e, farm, stre		Yes 2 □ No	28f. Location City or To			ural Route Number,
Hospital Hospital Hospital Funeral	Medical Ce	29a. Certifier (check only one) 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or in	occurred at the tile vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the	e cause(e, date a	s) and manner a nd place, and du	s stated. le to the cause(s)
within 2 to the comple	Mec	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	ate signed (Mont	h, Day, Year)
		MULT. ME	DICAZ DECTON	L	RES	000		AF	oril 05	. 2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OMATIC YOUSUF

31. Date filed (Month, 'Bay, Year)

32. Registrar's Signature

ORIGINAL

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ State		ment of Health and <i>iicate of Death</i>	Mental Hygiene	711114 171	507
		Registrar 1. Decedent's Name (First, Middle, Last)		Todio o. Dodi.	2. Date of Death	3. Time of	Death
Physici	an	Chise and			Month Da	y Year	
/Medi		Ia. Facility Name (If not institution, give street and number)		o. City, Town, or Location of De	64 L	. County of Death	747
Examir	ier	RANDORF HILL NURS		WHEATON, 1		Yout go were	9
Funeral			rs. last birthday)	Under 1 Year If Under 24 H	S. 9 Date of Rirth	9 Pirthnlace (State o	Foreign
Director		213-04-4365 10 M 20AF 8	4 Yrs. M	onths Days Hours Mi	n. (Month, Day, Year)	25 South Kar	EA
ъ		Jsual Residence of Decedent					
rylar show	_		City, Town or Location			10d. Inside Cit	
e Ma Ba-f	cto	MID MONEGOMERY	Potor	TAC		1 X Yes	2 No
or 2	Director	Ioe. Street and Number	1	0f. Zip Code	10g. Cit	tizen of What Country?	
ath w	Funeral	8313 FOX RUN		20854		th KOREA	
er de	nne	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	 Race - American Indian, Black, White, etc. 	
36 ", or	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No If Yes, Give 3 █ Widowed 4 ☐ Divorced Year or Dates:	1 🗆	Yes 2. No Specify:		Specify: ASIAX	/
d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ant, the Medical Examinat must be netitied at	pa	15. Decedent's Education	16a Decedent	's Usual Occupation	16h K	Kind of Business/Industry	
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vith yiene r thau	E	Elementary/Secondary (0-12) College (1-4or 5+)	1400			Domostic	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing A	ddress (Street and Number or	Rural Route Number, City	or Town, State, Zip Code)	
Mind 2 auth 2 127 is er tra		MICHAEL OM (SOM) 83/3	FOX RUNI P	otoMAC,	MD 20854	/
Baltimore, bermit. Pages 1 ar Department of Hee Important: If item iny Injury or othe once.		20a. Method of Disposition 20	b. Place of Dispositio cemetery, cremato			ocation - City or Town, State	
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/Medical		disease or condition resulting in death) Due to (or as a con		+1CV (TICICC	<u> </u>		
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O, O		resulting in death) Last Due to (or as a con-					
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riffice artifice ing pl	Med	IF FEMALE:			T		
Box 6 eath certificate attending properties as	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pre		topic pregnancy		23d. Date of delivery	,
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law law bas b	ald t				24a. Was an autopsy	24b. Were autopsy findings a	available ause of
The The page	ပ္ပ				performed? 1 □ Yes 2 No	death?	
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Division of the death Director:	ij.	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, street, ec <i>ify)</i>	factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Num 'e)	ber,
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my	kanudad	arrand at the state of the stat			
Hos 24 ho Fune	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my 2 ★ Medical Examiner: On the basis of examiner and manner stated.	nination and/or invest	curred at the time, date and platigation, in my opinion, death of	ace, and due to the ca <i>u</i> se(s ccurred at the time, date an	and manner as stated.d place, and due to the cause(s	;)
o the ithin o the o the o the	Mec	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)	
F×Fö		Dr. Pra son senter	M.D.		1	-6	7
	}	30. Name and address of person who completed cause of death (- 1	, 10 . 0	1
3		30. Name and address of person who completed cause of death (1 SCCEANS L	N Siste	162 Rockustil	a MD
Sta	nte.	31. Date fled (Month Day, Year) 32. Registrar's	gnature	1 -(-1,-1,0))/	2450
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DHMH 17 Rev 1/2001

State

Registrar

(Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mont Saczunsk **Physician** 6 Q M ohn 2009 Apri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth
(Month, Day, Year)
Jan 14, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Funeral Days Months Maryland 1 **X** M 2 □ F 87 217-09-6755 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show at Yes 2 No Baltimore City Md. Director 28a-f must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 6 U.S.A. 21224 6617 Gary Avenue items 23a Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. h and Mental Hygiene. 7 **Is marked other than "natural", or** iter traumatic event, the Medical Examiner I 1 Yes 2 If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Flementary/Secondary (0-12) Fawn Plastics Com. Tie & Die Maker 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Boro Joseph Sarzynski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Hedge Fort Court Nottingham, Md. 21236 19a. Informant's Name/Relationship (Type. Print) John Sarzynski, Jr. int of Health a t: If item 27 Is 7 or other trai (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery 4-20-2009Baltimore, Maryland Department or Important: If i any injury or once, 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 Tolor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsy **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) physician an resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 2**X** No 1 Yes 1 TYes certificate 26. Place of Death Check onl one 25. Was case referred to medical Be examiner?
1 Yes 2 No Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No death. Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, Could not be 3 Suicide determined City or Town, State) 4 - Homicide within 24 hours a 1% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one)

State Registrar 29b. Signature and title of certified

Lauren 31. Date filed (Month, Day, Year)

Registrar's Signatur

Block, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Block

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G890, 4/20/09, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 2009 15 Lton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital of Curity Number 6. Sex Balhmore Baltmore Balhnesse Date of Birth (Mont2.9)ay, 9. Birthplace 217-16-8482 **Funeral** Days Year) Country Months Hours Min Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show "natural", or items 23a or 28a-f shovediral Examiner must be notified at attimole 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Black <u>ک</u> 3 Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Mediral. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shelpo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Bultimore, MD 21216 Car SON Baltimore, NI II lam 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20.09 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) Gleine Funical Services 21. Signature of Funeral Service Ligensee Ighr 5151 Baltimole Wate 23a. Part1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or failure. List only one cause on each line. immediate Cause (Final **Physician** 30 minutes lax disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner thuroscluchc fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): and Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Known IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Hunknown Parient Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No Division or Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 [] inpatient 2 R/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) H0065959 who completed cause of death (Item 23a) (Type, Print) Poclvidere Ave 2401 Baltmore State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registra Certificate of Death 3. Time of Death 2. Date of Death Year 3:04 PM **Physician** 2001 Di Na /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Agres atrimone Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F If Under 1 8. Date of Birth (Month, Day 01 02 vrs. last birthday) **Funeral** Days Months Hours Min. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinating to use the published at Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 enue Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Black ò 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working Tie. DO NOT use retiled) Elementary/Secondary (0-12) College (1-4or 5+) Norker 18. Mother's Name (First, Middle, Maiden Surname, Be (nna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) on D 21229 20b. Place of Disposition (Name of cemptery, grematory or other place) Balto. Date Baltimore. 20c. Location - City or Town, State Method of Disposition 1≱Burial 2 □ Cremation 3 □ Removal from State Baltimore. trbutus 4 □ Donation 5 □ Other (Specify) 21. Signa re of Funeral Service License Services 5151 Balton natil Tilce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine burial-trar Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical the attending p IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie BP9619430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Da Hani 900 caton Ave Sanjay 32. Registrar's State Registrar

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inton Savage	State of Maryland / Department of Health and Mental Hyglene 1-For State Certificate of Death Reg. No. 2 1 9 1 25
Physician/	Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year April 11, 2009 3. Time of Death April 11, 2009
edical Examiner	April 11, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	2810 Winwood Court Baltimore Winder 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or
Funeral Director	5. Social Security Number 6. Sex 7. Age (III yis. last olimical) Months Days Hours Min. C+ 24 1981 Foreign Country) Many and
Director	Usual Residence of Decedent
w any	10a. State 10b. County 10c. City, Town or Location Park ville
ryland a-f sho	
with the Maryland ms 33a or 28a-f show any be notified at once.	
r death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Test of No.) 14. Was Decedent of Hispanic Origin? (Specify Test of No.) 15. Was Decedent of Hispanic Origin? (Specify Test of No.) 16. White, etc.
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21215-0036 uld be filed within 77 Mental Hygiene. marked other than c event, the Medica	1000000
	19a. Informant's Name/Relationship (Spe. Print) 19a. Informant's Name/Relationship (Spe. Print) 1306 Deanwood Rd. Baltimore, Maryland
- P # E E	20s. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Tow State
Baltimore, permit. Pages I a Department of He Important: If ite	1 Burial 2 Cremation 3 Removal from State H. Zion Centery 4/18/09 Landsdown Maryland
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Parker Funeral Home, P. A. 2029 35.17 Forderick Ave. Battimere Manuara
	Approximate Interval Between Onset and
Physician ledical	failure. List only one cause on each line.
aminer	or condition resulting in death) Due to (or as a consequence of):
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
0, be executed sician and burial - transit	d. S ON THE NAME OF THE STATE
60, ate be es hysician e burial	23d. Date of delivery
687 certifica nding p	23b. Was decedent pregnant in the past 12 months? Live birth Day Teal Annual Company Compa
Box e death the atter	1 Yes 2 No 9 Unknown 9 Unknown
Division of Vital Records, P.O. Box 68760 pital or Attending Physician: The law requires that the death certificate ours after death. British Director: After this certificate has been signed by the attending physicial or the funeral director, page 2 should be detached for use as the b	1 Yes 2 No 3 Probably 4 Ulikilowii
ds, I	24a. Was an autopsy prior to completion of cause of death?
ecor he law i	1 V Yes 2 No 1 V Yes 2 No
tal R cian: T certifica ector, p	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Scene
of Vit g Physic her this	1 Ves 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion c tending eath. tor: Af	(Month Day Year) 1 Natural 5 Pending 2 Accident Investigation 1 Yes 2 No Subject Shot 1 Yes 2 No Subject Shot Subject Shot Subject Shot Subject Shot 1 Yes 2 No Subject Shot Shot Subject
Jivis Il or At Safer d I Directed in by	3 Suicide 6 Could not be determined (Specified Local Street) 2810 Winwood Court, Baltimore, MD
To the Hos within 24 h To the Fur	and manner stated. 29d. Date signed (Month, Day, Year)
	29b. Signature and title of certifier O.C.M.E. April 12, 2009
	30. Name and address of person who completed cause of death (Item 23) Zobiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
4 1	Zabidian All, W.D. Yoshian Weden Sanature
S Regis	APR 20 2009 June S. Sall
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:30 P M Burton E. Stanley **April** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 Year If Under 2 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Director 093-18-2434 Sept. 22, 1913 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo <u>Virginia</u> Fauguier Warrenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 5721 Greenview Lane 20187 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wif Department of Health and Mental Hygien. Important: If Item 27 is marked other thi any Injury or other traumatic event, the once. Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Wayne Stanley Lillian Jopson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5721 Greenview Lane, Warrenton, Virginia 20187 Joanne Stanley/Daughter 20b. Place of Disposition (Name of Montgometry, crematory or other place) 20a. Method of Disposition April 16, 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 2009 Bethesda, Maryland Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Surfice Licensee M00198 23a. Part1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Cerebral Vascular Accident March 2009 Sequentially list conditions, if any leading to mine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse wence of) Examiner Hypertension il or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Years Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dysphagia, Immobility 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 💢 No 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗶 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a To the Funeral C the

> susan J. Miller, M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who

title of certifier

29b. Signature and

Impleted cause of death (Item 23a) (Type, Print)
1.D. 8218 Wisconsin Avenue #305, Bethesda, Maryland 20814 park

and manner stated

State

Registrar

29c. License number

D35579

29d. Date signed (Month, Day, Year)

16/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Warrand hospitality of Health and Mental Hygiene? [] [] 9

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician APRTL 17 2009 SCHLISSEL 12:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 10/19/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 M F NEWYORK 215-56-0121 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or than "natural", or items 23a or 28a-f shorthe Modeal Examiner count be notified at 1 □Yes 2 No OWINGS MILLS MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 8019 VALLEY MANOR ROAD #3A USA by Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examinati 1 ∐Yes 2 X No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔣 No Specify: WHITE 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER DRY CLEANER 18. Mother's Name (First, Middle, Maiden Surname) MILLER 17. Father's Name (First, Middle, Last) Be GORDON SAMUEL CELIA ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8019 VALLEY MANOR RD #3A, OWINGS MILLS, MD 21117 MYRNA LAZAR/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State MENORAH GARDENS 4/17/2009 WEST PALM BEACH, FL 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. emplicanous of Dementin Immediate Cause (Final **Physician** ens disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past/12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death certificate has been signed by the irrector, page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 L 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifie crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chanes St. #203, Baltimore, MD 21204 CHANNES 31. Date filed (Month, Day, Year) State

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Registrar

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DHMH 17 Rev 1/2001

Box 68760. P.0. Division of Vital Records,

Certification: To 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALT MORE, MD 2124 D 4940 M Linda Mobula 31. Date filed (Month, Day, Year, 32. Registrar's Signat State APR 20 2009 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:00 AM M April 7, 2009 Emory W. Toomey Sr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 4206 Baltimore Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug II, 19 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F 76 1932 Maryland 218-28-7804 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow 27 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4206 Baltimore Street 21227 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) mould polisher glass manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be in marked o Charles Emory Howser Toomey Elizabeth Dalziel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia M. Toomey/spouse 4206 Baltimore Street Baltimore, MD f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H importent: if ite any injury or oti once. 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Director 21. Signa ure Juneral Service Licensee / Wave State Anatomy Board 655 W. Baltimore Street me Baltimore, MD 21201 Baltimore, MD 21201

25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** physeing /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner Hospital or Attanding Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2√2 No ours after death.

neral Director: After this certifice filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 🗀 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 14^{Pay} 2009^{ear} **Physician** Torrieri 5:25 P M Peter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Riderwood If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Numbe Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2 □ F 214-16-9835 92 Pennsylvania 12/8/1916 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Everainer rust be notified at once. Parkville 1 ☐ Yes 2 X No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 21234 8820 Walther Blvd. USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2XXMarried 2 💢 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Advertising Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Domenico Torrieri Maggiorina Negro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Hidden Valley Lane Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type. Print) Don J Torrieri / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment Dulaney Valley Mem 4/19/2009 Timonium, Maryland 22. Name and Address of Facility Towson, M. Ruck Towson Funeral Home, Maryland 21204 e, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Dementia Physician /Medical Due to (or as a consequence of): Examiner Adult failure to thrive Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physiclan; The law requires that the death certificate be executed burial-transi Dysphagia and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) I Yes 2 □ No certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Weight Loss Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □ Yes 2 □ No 1 ☐Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check online) Hospital: Other: 4 🛮 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 15, 2009 D59524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Loveen J. Puthumana, 3110 Gracefield Road, Silver Spring, Maryland 20904

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State

Registrar

31. Date filed (Month, Day, Year)

APR 20 2009

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9&18perFH G890 4/28/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:45a 2009 April John George Walk /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Longview Mursing Home Manchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 22,192 9. Birthplace (State or Foreig Country Mary Land 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days **Funeral** Hours Min. Months 1 ☑ M 2 ☐ F 217-14-9172 87 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be notified at 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Director Hampstead Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21074 Unit 3754 Shiloh Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 □ No If Yes, Give TW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Saltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Builder Custom Builder 18. Mother's Name (First, Middly Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth No John Walk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3754 Shiloh Rd. Unit 5 Hampstead, MD. 21074 Flora Walk - wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory April 20,2009 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21. Signature of Funeral Service Licensee . Hall Tell X 21102 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HOVANCED disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Chanic Kidwa Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-trans Monie Due to (or as a consequence of): physician the burial P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year □Yes 2□No ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 2 No 1 □Yes 2 No 1 ☐ Yes certificate e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0060583 4/20/09 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mampstead, MD 21074 Amy Staritz, MD 2111 Manover Pike 32. Registrar's Signature 31. Date filed (Month; Day, Year) State APR 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7&8 Pestate of Maryland Department of Health and Mental Hygiene

For State Registral Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 16, 2009 Ronald L. Werner 11:56A.[™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 7801 Peninsula Expressway, 223 Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1945 9. Birthplace (State of Sept 26, 1946 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**Ϫ**M 2□ F Months Days Hours Min. 63 215-46-7560 -62Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygjene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Evanders: sust be notified at 1 ☐ Yes 2 No Directo Dunda1k Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 7801 Peninsula Expressway, 223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★1Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u></u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Martin's Sand Blaster 3.2 should be filed with and Mental Hygier 7.1s marked other the yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Urbanowski Ernest W. Werner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traunonce. 1719 Stokesley Road Dundalk, Md. <u>Stacey Werner (Daughter)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition M Burial 2 Cremation 3 Removal from State 4-21-2009 Baltimore, Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cirrhosis of Liver years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its leads of the cause). Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Tyes 2 No. 9 Unknown s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obesity 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Sleep Apnea 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Chronic Atrial Fibrillation 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural ours after death, leral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ŏ To the Hospital within 24 hours a To the Funeral I 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sun D 33407 April 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Seth, M.D. 207 Wise Avenue Dundalk, Maryland 21222 Deepak Seth, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 20 2009

32 Registrar's Signat

Amend #25 per ME g891 5/8/09 TT

Amend Please Type of Print in Black Indelible in the Ensure All Copies Are Legible. Amend Item 23a per dr., 1889 0,04720,09dhb Certificate of Death Reg. No. For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:32 P M MARCH 19, 2009 CANDACE EVE WILLIAMSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 6612 RONALD ROAD #201 CAPITOL HEIGHTS Birthplace (State or Foreign Country)
 DC If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB. 27, 1 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days 1 □ M 2 🕅 F 39 1970 Director 578-92-2372 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director PRINCE GEORGE'S CAPITOL HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6612 RONALD ROAD #201 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2X No Specify ð 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. " Important: if item 27 is marked other than "r any Injury or other traumatic event, the "Not once." Elementary/Secondary (0-12) College (1-4or 5+) 12TH SECRETARY IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Be PATRICIA SEARS မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEMPLE HILLS, MD GEORGE JONES / BROTHER 5308 ACORN DRIVE 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 03/20/09 Alexandria, VA 4 Donation 5 Dother (Specify) LINCOLN MEMORIAL CEM. 103-27-2009 -SUITLAND, 21. Signature of Funeral Service License 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD Machain Male Be SHAUN L. WATTS 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of): Examiner Probable Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 🛣 No 5 Other (specify) detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð pe 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 🗆 No Division of Vital 1 ☐ Yes 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ည MARCH 23, 2009 D0061148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

GARY HARRINGTON

APR 20

31. Date filed (Month, Day, Year)

8241

32. Registrar's Signature

GEORGIA AVENUE STE 102

20910

SILVER SPRING, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Laura Weeks /Medical 4a. Facility Name (If not institution, give street and number, City. Town, or Location of Death 4c. County of Death Examiner General N/A If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) urity Number Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1 □ M 2 👿 F Director 212-34-4870 74 Oct 24, 1934 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Medical Examinar must be notified at Baltimore 1 XYes 2 No Director Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2013 North Fulton Avenue 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tylo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify. Specify. 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any liqury or other traumatic event, Ins. 100ce. Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hattie T. Edwards Bernard Edwards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 Gwynn Falls Parkway Baltimore, Maryland 21216 Duane Stewart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ NBurial 2 ☐ Cremation 3 ☐ Removal from State 04/21/09 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 21. Skonatur of Funeral Service Liou see 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Jerotic **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760) attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1) Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō thin 24 hours a 29a Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical o the hu within 2 To th and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0067207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) inden Ave. Baltimore, MD 21201 Vo 31. Date filed (Month, Day, Year) State APR 20 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	/Medic	al	DIT	WILEY		4h Cihr	Town or Loc	ation of Death	04	4c Coun	ity of Death	11272
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			HOLY CROS 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)		1 Year III	SPR Under 24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign
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Maryland	d 2 shou th and M 7 ie mar traumat		19a. Informant's Name/Relationship (Type	e, Print) •	19b. Mailir	ng Addres	s (Street and	Number or Run	al Route Numbe	r, City or Tow	m, State, Zi	ip Code)
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Baitimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	l ce	lace of Dispo emetery, cren	sition (Na natory or	me of other place)		Date	20c. Location	n - City or T	Town, State
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Т			23a. Party. Enter the disease, or complications, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ent	er the mo	de of dying, si	uch as cardiac	or respiratory ar	rest,		Approximate Interval Between
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ř	Physician: The la r this certificate her aral director, page 2	E							perfo	rmed?/ 2 No	death?	2 No
ita	ian; rtifics stor, i	a a	25. Was case referred to medical	/			26	S. Place of Deat	h (Check only o	ne)		
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0	19 Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of	28c. Injury at Work?		28d. Describe I	now injury occ	curred	
Ö	death. ctor: Af the fur	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	,		М		2 □No				
<u> </u>	Pr de Br de Frecto	E C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	reet, facto	ry, office		28f. Location (S City or Tov		mber or Ru	ırai Route Number,
Ω	rs after al Direction Direction of the D	Certification;										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	cian: To the best of my kno	wledge, deat	h occurre	d at the time,	date and place,	and due to the	cause(s) and	manner as	stated. to the cause(s)
	the H in 24 the F iplete	Medicai	one)	and manner stated.								
	Vith To T	2	29b. Signature and title of certifier			2	9c. License no			29d. Date sig	nea (Month	i. Day, Year)
			1 (3/11	na)			N26	153		4-1	12-	04
			30. Name and address of person who con	npleted cause of death (Item	1 23а) (Туре,	Print)						
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1	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Régistrar's Signa	ature A	back	A. Carrier					
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09-02922 Chad J. Waynik Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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State Page 2 A Sequentially list conditions, if any, leading to immediate cause of certific resulting in death) Due to (or as a consequence of): Due to (or as a consequence	/Medical		failure. List only one cruse on each line.			Between Onset ar
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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of beath (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ਰ ਨੂੰ ਛੋ ਂ				23d. Date of de	elivery
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P.O. Box 68760, Division or Vital Records,

Hospital or Attendl 24 hours after death. Funeral Director: A completely filled in by the To the Hospital within 24 hours at To the Funeral C

(RU) State Registrar

Certification: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 2, 2009

30. Name and address of person who completed cause of death (Hern 23a) (Type, Print)

110 Hospital Rd., Suite 310, Prince Frederick, Maryland 20678 Weigel, MD John H.

32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 03 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** John Edward Asberry 2009 6:44 a April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital Elkton Cecil If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 ☐ F Yrs. Director 218-78-2556 51 MD October 17, 1957 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 Yes 2 □ No Director MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Items 23a or it De e ms 23a 148 Mike Court Completed by Funeral 21921 USA ral", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 Divorced ear or Dates: White er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Certified Financial Planner Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Wiley E. Asberry <u>Lois Ann Rogan</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10798 Green Mountain Circle, Columbia, MD 21044 Joseph W. Asberry/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or R.A. Ferris & Co., Inc. April 7, 2009 West Chester, PA Ment Service Licensee Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MELANOMA MALIGNANT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the incention in death). Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ After this certificate has been signe funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation in 24 hours after death.

In Funeral Director: A sletely filled in by the filled in th 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P. V. Nonge N 1) 0065 733 05/29

State Registrar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 03/ 28/ 2009 1815 PATRICIA ANN BARLEY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CUMBERLAND nder 1 Year | If Under 24 Hrs. ALLEGANY ALLEGANY CO. NURSING & REHAB. CTR. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, If Under 1 5. Social Security Number 6. Sex Days 1 ☐ M 2 🂢 F 03/10/1949 Yrs. MARYLAND 219-54-2075 60 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 ☐ No CUMBERLAND ALLEGANY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #1 BALTIMORE STREET 21502 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 XNo 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) GOODWILL INDUSTRIES Elementary/Secondary (0-12) College (1-4or 5+) FOR THE BLIND CLERK 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANNA CECELIA FRADISKA EDWARD LEO BARLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 463, MT. SAVAGE, MD KATHLEEN CLARK / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 03/30/2009 CUMBERLAND, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PAYS ASSIRATION INSV MODIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of

Physician /Medical **Examiner** use as the burial-transit certificate be executed Box 68760

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Baltimore, Maryland 21215-0036

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Division of Vital Records,

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier uspound THUME 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009 State Registrar

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

5 Pending investigation

6 ☐ Could not be

determined

Barrera 32. Registrar's Synature and

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

500

Ave, Cumbarland, MD 21500

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** William Brant March 21, Charles 2009 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1007 Frederick Street Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 □ F 91 Director 214-07-2375 05/22/1917 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, It of Marical Evanified and any injury or other traumatte. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No Director MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1007 Frederick Street 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ 3 X Widowed 4 ☐ Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Bank 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brant Bertha Agnes Horton Charles Henry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon L. Brandes / Daughter 1533 Shadyside Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/24/2009 Everett Cemetery Everett, PA 21. Sign itu e of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 425 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physlcian: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 NResidence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only To the within 2 one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0014865 22, 2009 March sano dawne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano J. Barrera, M.D., 500 Memorial Avenue, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 23 Barks Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 2529 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death V:35 AM Month Year OWEN KENT BARNCORD 20,2004 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) THE LIONS CENTER CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1**∑**M 2☐F 73 214-34-2017 03/21/1935 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No WV MINERAL RIDGELEY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 26753 ROUTE 3, BOX 386 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: '54'-57 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TIRE TIRE BUILDER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEORA LEPLEY JOHN BARNCORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUTE 3, BOX 386, RIDGELEY, WV BARBARA BARNCORD / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State RESTLAWN MEML.GARDENS 03/23/2009 LAVALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21. Signature of Funeral Service Licensee Derwich 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the 15 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Gustric Cancer à metastasis 2 months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 TYes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica director,

Examine burial-tran attending physician for use as the buria Physician/Medical þ Completed Be P Certification:

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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Funeral

Director

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artment of Heatith and Mental Hygiene. ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 a. Department of Hea. Important: If item 2 any Injury or ...

Physician

/Medical

Examiner

within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral

State Registrar

Medical

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

MD

00055325

March 20,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year) MAR 24 32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 7, 6:00 a April Marie Lulu Barnes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mechanics ville St. Mary's 26191 Mara-Lee Drive If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Maryland Director 578-18-6280 89 07/25/1919 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations authorities authored. 1 ☐ Yes 2 X No Directo Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 26191 Mara-Lee Drive 20659 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2K No Specify: Specify: þ 3 X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Food Service Worker Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Albert Butler Cecelia Maria Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Delores A. Butler/Daughter</u> 3200 Lumar Drive, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place)
Immaculate Heart
of Mary Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spepify) 104/14/2009 Lexington Park, MD 21. Signature of Funeral Serve Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER ANCILEATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Š HYPERTHYLOIDIEM 1 ☐ Yes 2 ☐ ►NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

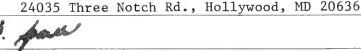
completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier-D50076 MD

31. Date filed (Month, Day, Year) State **APR 07** Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:15 a M 2009 April Brice /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Days Min Hours 1 X M 2 □ F Maryland 15,1919 89 Nov. Director 011-16-7818 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be muffled at once. 1 ☐ Yes 2XXNo Berlin Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 3 Offshore Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ∐Yes 2 ⊠No Specify. Specify ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Printing Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DeHaven Brice Μ. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellynne Brice Davis/Daughter 20832 Waterside Dr., Leonardtown, MD 20650 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Charlotte Hall, MD 04/08/2009 Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licenses Kyle Simons MOT206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Loncer **Physician** ung disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 Who 1 □ Yes 2 No or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attend within 24 hours after death to the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H64428 04/05/2 9733 Healthung Brive pital Berlin, MD 21811

Registrar DHMH 17 Rev 1/2001

State

Jason 31. Date filed (Month

Baltimore, Maryland 21215-0036

Records,

Vital

Bria, Walter

Atlantic General Hospital

30. Name and address of person (m) completed cause of death (Item 23a) (Type, Print)

Szymala, no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amenc#16A Per FH State of Maryla State Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O G **Physician** GERTRUD 13 5 M Sarris 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 Z Yrs 1920 PA Director April 17, 88 171-16-8622 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be mutified at 1XXYes 2 ☐ No Annapolis Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number USA 21403 660 Americana Drive Apt 27 or Items 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √No Specify: Specify: White þ 3 X Widowed 4 □ Divorced neturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Adminstrator Administrator Education permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Importent: If Item 27 is marked other the any injury or other treumaric access. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Wall ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 660 Americana Dr Apt 27, Annapolis, MD 21403 Susan Aramayo - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 4/6/2009 Baltimore, MD A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between fiset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transi and that initiated events the death certificate be exec resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? signed by the at id be detached fo 5 Other (specify) 1 ☐ Yes 2 Z No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 2 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 nerel Director: After th filled in by the funeral 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: (Month, Day Year) 5 Pending investigation 1. Natural death. 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number me and address of perso pleted cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day,

DEFENSE HIGHWA 32. Registrar's Signature

m 445

Registrar

NAPOUS MDZI

09-02907 William Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 12533 Certificate of Death 1. For State Reg. No 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 11, 2009 1419 hrs Brown, Jr. Medical Examiner Ambrose William 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Laurel Regional Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Min Months Days Country) Maryland 08/25/1972 Director 220-78-0990 1X M 36 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1 Yes 2 X No 28a-f show 23a or 28a-f shornotified at once. <u>Lexington Park</u> Maryland St. Mary's with the Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number United States 20653 21275 Lexwood Court, Apt. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes ö Specify Black Yes 2 X No specify: If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Widowed Divorced "natural" ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) marked other than " c event, the Medical I 21215-0036 Jail 12 Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Taylor Maxine Brown, Sr. Sarah marked William Ambrose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20653 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 28-B Lexington Park 21275 Lexwood Ct. Sarah M. Taylor/Mother Hitem 2 her traum 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State 1 X Burial 2 4/18/2009 Leonardtown, MD Charles Memorial Donation 5 Other Specify 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Rd., Leonardtown, MD Kyle Simons M01206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical Hypertensive cardiovascular disease Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit X AMENDED #1,23a,PII,27,perME, g890 4/24/09 TT Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial res that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> 1 Yes 2 ✔ No 3 Probably 4 è Chronic renal disease; diabetes mellitus; obesity; Completed 24b. Were autopsy findings available 24a. Was an Division of Vital Records, The law requir prior to completion of cause of has been autopsy hyperlipidemia death? performed? Yes 2 1 🗸 Yes Nο page certificate 26.Place of Death (Check only one) the Hospital or Attending Physician; 25. Was case referred to medical Be Other₄ examiner? Residence 6 Hospital: 1 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA this 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 12, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. gistrar's Signature 32. R 31. Date filed (Month, Day, Year) State 5 2009 acced. Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

10d. Inside City Limits

1 ☐ Yes 2X No

10a. State

MD

1. Decedent's Name (First, Middle, Last) **Physician** JUDITH /Medical Examiner

Certificate of Death

BELYEA

62

2. Date of Death 3 Time of Death Month 8:15P M APRIL 10 2009

4a. Facility Name (If not institution, give street and number) 4652 DEEP SPRING PLACE

ANNE

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

10e. Street and Number

11. Marital Status

223-58-6701 Usual Residence of Decedent

7. Age (In vrs. last birthday) 6. Sex 1 □ M 2 🔀 F

WALDORF If Under 1 Year | If Under 24 Hrs. Months Days

8. Date of Birth (Month, Day, Year) Hours Min MAY 8,1946

CHARLES Birthplace (State or Foreign Country) VIRGINIA

Funeral Director

the Maryland show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinator must be inclined at Director permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" consumption or other traumatic events. Funeral à Completed Be

Physician

/Medical Examiner

> and burial-trar

> signed by the attending physician be detached for use as the burial

cate has been signated by page 2 should b

certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Medical

10c. City, Town or Location CHARLES WALDORF

10f. Zip Code

10g. Citizen of What Country? U. S. A.

4652 DEEP SPRING PLACE

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 🛣 No Specify

14. Race - American Indian. Specify: WHITE

1 ☐ Never Married 2 ★ Married 3 Widowed 4 Divorced

Elementary/Secondary (0-12)

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20601

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

GENERAL MANAGER

SCAFFOLD RESOURCES 18. Mother's Name (First, Middle, Maiden Surname)

WILLIAM CLAUDE CHAPMAN

19a. Informant's Name/Relationship (Type. Print)

GERTRUDE ELIZABETH CAULDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RALPH BELYEA / HUSBAND

4652 DEEP SPRING PLACE WALDORF, MD 20601

20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM.GRDNS.

20c. Location - City or Town, State 15, 2009 WALDORF, MARYLAND

21. Signatuje of Funeral Service Licensee. osen Baston

5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

	Due	to	(or a	as a	consequence of):	
_	Due	40	Nau .		consequence of:	

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

24a. Was an autopsy perform 1 ☐Yes 2 ☑No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical examiner? Be 1 Yes 2 No Certification: To

27. Manner of Death 1 Natural 2 Accident 3 Suicide

5 Pending investigation 6 ☐ Could not be

determined

20

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 □Yes 2 □ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of of

29c. License number D42509 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH no 12010 DLP LINE CH2 4100 MBINDER

Hospital:

31. Date filed (Month, Day, Year)

APR

32. Registrar's Signature

Bourte

State Registrar

Dr

09-02710 Robert Constant

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$1286 of Frank End 6890 at 1/23/109 Health and Mental Hygiene

2009 12535

		1- For State	Certificat	te of Death	•	Reg	. No.	
Physici	ian/	Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death 2119 hrs
edical Exam	iner	Robert Alan Consta				April 5, 200		
		4a. Facility Name (if not institution, give street		4b. City, Town, or Salisbury	Location of Death		4c. County of Deat Wicomico	'
		Peninsula Regional Medical Co			ar If Under 24Hrs	9 Date of Birth	(MM/DD/YYYY) 9. Bi	rthnlace (State or
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	day) If Under 1 Year Months Day		_	Forei	gn
Director		229-17-2749 1 XM	2 F 45	Yrs.		5/6/19	63 C	ountry) VA
	1	Usual Residence of Decedent	10c. City, Town or	- Leasting				10d. Inside City Limits
w any		10a. State 10b. County						1 Yes 2 X No
Maryland 28a-f show 1 at once.	- io	MD Worcester	Berlin	10f. Zip Code		110	. Citizen of What Co.	
Mary 28a- d at	Director	10e. Street and Number		and y ?				
h the] 3a or otifie		21 Brittany Lane		21811			ISA Dans Amo	rican Indian, Black,
th wit ems 2 t be r	Funeral		Armed Forces?	 Was Decedent of Hi If Yes, specify Cuba 	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	White, etc.	ilicali ilidiali, biack,
r dear or it	Ē		Yes 2 X No	1 Yes 2 X No	o pooific		Specify: W	hite
s afte	þ	3 Widowed 4 Divorced If Yes or D 15. Decedent's Education (Specify only high	ates:	ecedent's Usual Occupa		work done	16b. Kind of Business	
"nati	Completed			uring most of working life				
5-0036 fled within 72 Hygiene. d other than	를	9		echnician			HVAC	
d with	5	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle, M		
11215-0036 Id be filed within 72 hours af dental Hygiene. event, the Medical Examin	Be	Maurice Robert Con	stant		Joyce	Vaughan		
21, buld b I Men s mar	P	19a. Informant's Name/Relationship (Type,	Print) 19b.	Mailing Address (Stre	et and Number or	Rural Route Numb		te, Zip Code)
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tream 21s marked other than "matural", or items 23s or 28a-f she traumatic event, the Medical Examiner must be notified at once		Maurice R. Constan		21 Brittany				T. Chil
Te, land Heal Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 R	removal from State cremator	Disposition (Name of cory or other place)		Date	20c. Location - City of	or rown, State
MOFE Pages 1 tent of F int: If i		4 Donation 5 Other Specify:	Cape H	enlopen Cre	em. 4/	7/2009	Frankfo	rd, DE
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ining very, the Medical from than in the permit in the Medical from the permit in the Medical in the permit in the Medical in the permit in the Medical in the medical interpretation of the permit in the medical interpretation of the permit in the medical interpretation of		21. Signature of Funeral Service Licensee	,	22. Name and Addres	ss of Facility Bu	rbage Fu	neral Home	e
	'	hum, Thack	10d	108 Wil	lliam St.	. Berlir	. MD 2181	
Physician		23a. Part I. Enter the disease, or complicating failure. List only one cause on each line	ons that caused the death. Do not ne.	enter the mode of dying	g, such as cardiac	or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and
Medica camine			tiple Injuries					Death
		or condition resulting in death)	to (or as a consequence of):					
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence of):					
	aminer	cause. Enter Underlying Cause						
- gg		events resulting in death) Last Due	to (or as a consequence of):					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and compensated its last in which finessed insectors nace 2 should be decached for use as the burial - transit.	g	dd	MENDED					
60, ate be e	Medical		3c. If yes, outcome of pregnancy				23d. Date of deliv	ery
876 tificat ng ph	}	23b. Was decedent pregnant in the	Live birth 2	Fetal death 3	Ectopic pregn	ancy	Month	Day Year
Box 687 death certific	sician	past 12 months? 4 1 1 Yes 2 No 9 Unknown In	Pregnant at time of death 5	Other (Specify)			1	Į.
Bo dear the a	3 2	1 Yes 2 No 9 Unknown g			- siven in Dert I	23e Did to	hacco use contribute	to the cause of death?
P.O.			tributing to death but not resulting	in the underlying cause	given in Fatti.			robably 4 Unknown
S, P.C. uires that	31 =					24a. Was a		autopsy findings available
tal Records, cian: The law requir certificate has been s	plet					autop		o completion of cause of
Rec The la	E					1 🗸 Yes		Yes 2 No
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical	Sel.		ce of Death (Chec			-
Vit hysic this o	1 2	1 ✓ Yes 2 No	· I I I I I I I I I I I I I I I I I I I					her:
1 of V Jing Phy L After tl		27. Manner of Death 1 Natural 5 Pending	28a, Date of Injury 28b, T (Month, Day, Year) Apr 5, 2009 2247	Z-ben	njury at Work? Yes 2 ✔ No	Driver auto	now injury occurred collision	
sior ttend death.	atic	Pending 2 ✓ Accident Investigation		U/54nrs		OOF Lengtion (5	Street and Number or	Rural Route Number, City
Division of Vital Records, talor Attending Physician: The law requirers after death. The rib receiv: After this certificate has been side in by the finesed of sealth.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa		e building, etc.	or Town, S		Nural Noute Number, Oity
spita hours neral	Sel	4 Homicide 29a. Certifier 1 Continue Physician:	(Specify) Emergency Roo		I to such look on			tated
he Ho in 24 l	cal	(Check only one) Certifying Physician:	To the best of my knowledge, dea the basis of examination and/or in	ath occurred at the time, nvestigation, in my opini	date and place, ar on, death occurred	at the time, date	and place, and due to	the cause(s)
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	Medical	29b. Signature and title of certifier	manner stated.		ense number		29d. Date signed (
	2	250. Signature and title of certifier			C.M.E.		April 6, 2009	
		unac_	Little annual of the William (III) and A					
BA5		30. Name and address of person who com Ana Rubio MD. Assistant M	pleted cause of death (Item 23a) Medical Examiner 111 F	Penn Street, Baltir	more, MD 212	01		
פווע	Ctot	31 Date filed (Month, Day Year)	32. Registrar's Signature					
Reg	ञाता(ΔPR 0 7 2005	Beneur B.	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 10a State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 4/9/08 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Year Month Physician 2103 M Mamadou Chinyela April 20001 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland of Medical Center Baltimore MD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 № M 2 🗆 F 57 2/26/1951 Director PA 211-40-1707 Usual Residence of Decedent 10a. StateMD the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show event, the Medical Expressure must be notified at X□Yes 2□No Directo Silver Spring -131 PA Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ò "natural", or items 23a 20910 USA Funeral Fenwick 1316 Lane Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, The M Author 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Gaddy McCall Moses 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Washington Ave. ChevtChase, Md. 20815 McCall (Brother) James 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HavenRest Mem.Pk. 4/11/09 Shirleysburg, Pa. 22. Name and Address of Facility Robert D. Heath Funeral Home 21. Signature of Funeral Service Licensee Janel 2 .Alcelter E. Shirley St. Mount Union, Pa. 17066 MO1035 161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ena -Stage liver disease resulting in death) /Medical Due to (or as e col sequence of): **Examiner** end-Stage renal Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Hepathts -C Due to (or as a consequence of): attending physician a Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) hed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 □ Yes 2 ☑ No this certificate 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NID 04 2009 Coparla Carnon 19043 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH 2+1 South Baltimare, MD rejana

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 09

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Name (First, Middle, Last) 2. Date of Death **Physician** RGINIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7309 Malden Lane Forestville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 20, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 75 Yrs 579-42-9161 1933 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it a Prodical Exyral or other traumatic event, it a Prodical Exyral or 1 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 □ No Director MD Forestville Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7309 Malden Lane 20747 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Boyd Jimerfield Nellie Violet Bruce Reed ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis L. Schnake/Son 7309 Malden Lane Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit, Pages Department o Important: If any injury or 4/2/2009 Bayview Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens. Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one days on each line. Immediate Cause (Final WINELY Physician METASTATIC CA CERVIX disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 1∐Yes 2. No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier

Division of Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by completely within 2.

Maryland 21215-0036

Saltimore,

Registrar

31. Date filed (Month, Day, Year) APR 03

30. Name and address of person who

29b. Signature and title of certifier

(Check only one)

NIA MO 445 DEYENSE 32. Registrar's Signature

inpleted cause of death (Item 23a) (Type, Print)

and manner stated.

HOHWAY

09-02850 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffrey B. Cooling State of Maryland / Department of Health and Mental Hygiene 2009 12538 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day April 9, 2009 Medical Examiner 2145 hrs Jeffrey Burris Cooling 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 320 Friendship Road Elktor Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Davs Director Months 216-46-9985 Country) Maryland 1 X M 2 53 02/11/1956 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 X Yes 2 No Maryland Ceci1 E1kton permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 320 Friendship Rd. 21921 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 2 X No Yes 3 X Widowed If Yes, Give Year 1 Yes 2 X No specify: Divorced White Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 Maintenance Worker Building Maintenance 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Burris Cooling Martha Elizabeth Cheyney ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1560 Leighton Dr., Soddy Daisy, TN Harold C. Cooling/Brother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, 04-18-2009 1 X Burial 2 Cremation 3 crematory or other place) Removal from State Cheyney Family Burying Ground Donation 5 Other Specify: Cheyney, PA 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A.
318 George St., Chesapeake City, 21. Signature of Funer. ce Licensee 21915 3a. Part I. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. Ist only one cause on each line. Between Onset and /Medical Death Immediae Cause (Final disease Seizure disorder xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and tra Physician/Medical 23a,PII,27,28a-f,perME, g891 **6/03/09** TT physician a the burial -X UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? o þ ۵. 1 Yes 2 No 3 Probably 4 ✔ Unknown Remote head trauma Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 1 🗸 Yes No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one of Vital Be examiner? Other: Nursing Home 5 ___ Residence 6 ✔ Other: Scene this Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes ဥ No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural remote bike accident Yes 2 X No Director: d in by the f Pending 1980 within 24 hours after death. To the Funeral Director: unknown 2 X Accident Investigation ò 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide unknown 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 10, 2009

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2009

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 5, ^{Day}2009 Year **Physician** 12:25 P M Phyllis Lorraine Doughty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 17,1961 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 F 219-80-9487 47 Maine Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show ofical Examiner must be notified at 1 ☐ Yes 21 No Maryland St. Mary's California Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20619 44189 St. Andrew's Lane USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ⊠Yes 2∐ No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
Is marked other than "natur
aumatic event, ire Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Handyman Self Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Alfred Doughty Phyllis Evelyn Bodman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 44189 St. Andrew's Lane, California, MD 20619 Phyllis Evelyn Doughty / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 7 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Storature of Funeral Service Lipens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, F P.O. Box 270 Leonardtown, MD 20650 nchaels 23a, Parf1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Colon Immediate Cause (Final Cancer 3 years Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate has lirector, page 2 s autopsy performe 2 No 1 □ Yes 1 □Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: / investigation 2 ☐ Accident 6 Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 5 4346 M.D. 4/6/09 C baby 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHANDRA B·SAJJA, 24035 THREE NOTCH ROAD, HOLLYWOOD, MD 20636 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 7 2009 Registrar

DHMH 17 Rev 1/2001

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OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>009</u> **Physician** 14, Ethel Stine Dixon April 12:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Vindobona Nursing Home Braddock Heights <u>Frederick</u> 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 ☐ M 2 □ 108 1901 April 214-34-0675 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Eventual terminal terminal at once. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 □Yes 2√□No Director Braddock Heights Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 6012 Jefferson Blvd. 21714 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 1√2 No Specify: Specify: White XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George H. Stine Fannie Cramer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 West Second Street, Frederick, MD 21701 Mr. W. Jerome Offutt, PR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Apr. 20, 2009 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Reeney and Bastord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** accides Exchievers Culor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown nis certificate has been signed by director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: соmpletely within 2 To the I

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Christopher Fleming, M.D., 610 Ninth Street, Brunswick, MD 21716 31. Date filed (Month, Day, Year) 32. Registrar's Signature

29c. License number

D 37178

ORIGINAL.

29d. Date signed (Month, Day, Year)

April 14, 2009

and manner stated.

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland		rtment tificate				giene Reg. No.	2009	grander of	2541
			1. Decedent's Name (First, Middle, Las	st)						2. Date of De	ath		3. Time	e of Death
	Physicia /Medic		James Rex Freema							April	-	009 Year	5:20	0 дм
	Examin	er	4a. Facility Name (If not institution, given Chesapeake Shores		Center	r	•		ocation of Deat n Park	n	4c. C	St. Mar	y's	
	Funeral		Social Security Number 6. S		e (In yrs. la 73		If Under	_	If Under 24 Hrs Hours Min.	(Month Da	th ay, Year)	Coun	try)	te or Foreign
	Director		227–42–8745 Usual Residence of Decedent		/ 3	YTS.				May 10	, 193	5 Virg	ginia	1
1	M N		10a. State 10b. County		10c. City,	Town or Loc	ation					1	0d. Inside	e City Limits
Mon	Type 1	ţ	Maryland St. Mar	y's		Ca	.11awa	ıy					1 🗆 Y	es 2X∏No
4	or 28	Director	10e. Street and Number				10f. Zip	Code			10g. Citiz	en of What Coun	try?	
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OCOO	point. Tages I should be alread within 2 hous side death mit the maryand Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Eventual to notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent If Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Vas Decede Yes, speci □Yes 2		spanic Origin? (S I, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		4. Race - Americ Black, White, e Specify: Whi	etc.	1,
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7 L	e. Medi	Completed	(Specify only highest gra	College (1-4or 5	5+)				uring most of wo		Mary	land Sta	ate 1	Highway
7	lygien her th					Ma	inter		Worker	me (First, Middle				
מונים	ental F ked ot ic ever	To Be	17. Father's Name (First, Middle, Last) Leonard Walker Fi						16. Moulet S Nai	Venus	, walden S	Moore		
ar y	and M s mar	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address	(Street a	nd Number or R	ural Route Numb	er, City or	Town, State, Zip	Code)	
ક, દ	ealth n 27 I		Charles V. Freema	an / Nephe								rk, MD 2		
	nent of H nt: If iter ny or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ce	ace of Dispos metery, crem opolita	atory or ot	her place	1	1 9, 2009		ation - City or To ndria, Vir		
	Departm Departm Importa any inju		21. Signature of Funeral Service Licer		(2)	22.	Mattir	igley-	s of Facility Gardiner	Funeral H dtown, MD	ome, P	.A.	1.75.00	
ь	hysician	2 3	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lin	d the death.	Do not ente								mate Between and Death
	/Medical xaminer	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as b. Due to (or as c. Due to (or as d.	a con teque	ence of):	15	. ف		9			je -	cers
the death certific	within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 🗌 Fetal	death 3	Ectopic pr				2	3d. Date of delive	ery Day	Year
rus, r	in signed b	ed by Phys	Part II. Other significant conditions of	ontributing to death b	out not resul	ting in the un	derlying ca	ause give	n in Part I.		tobacco us Yes 2□	se contribute to the		of death?
The law requires	cate has bee	Completed			-					24a. Was auto perfi 1 □Yes		24b. Were auto prior to co death? 1 □Yes	mpletion	of cause of
VILAI	ertifi ector,	Be	25. Was case referred to medical examiner?							ath (Check only				
5	this c	၉	1 Yes 2 No			R/Outpatien						Other (Special	(y)	
	th. After funer	tion:	27. Manner of Death 1	28a. Date of Inju (Month, Da	ay, Year)	28b. Time of Injury	м 2	Bc. Injury Work' 1 □ Y	rat ? ′es 2 ∐No	28d. Describe	now injury	occurred		
DIVISION	s after dea	Certification:	Suicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. City or Town, State)									Number,		
Hoenie	e Funera letely fille	Medical (29a. Certifier Certifying Pt (Check only one)	hysician: To the best miner: On the basis o and manner st	of examinati	vledge, death ion and/or inv	occurred vestigation,	at the tim in my or	ne, date and place pinion, death occ	e, and due to the curred at the time	e cause(s) , date and	and manner as s place, and due to	stated. o the cau	ise(s)
,	withir To th comp	Me	29b. Signature and title of certifier	Alalo	les	u	290	. License	number 60 U	6	29d. Date	e signed (Month,	Day, Yea	no 9
6	the		30. Name and address of person who Amir Mirza Alikhani,					ito R	P O Ros	1890 I.a	Plata	Maryland	206/1	5
5	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signati		- A	LLC D	, 1.0. 102	1070, 10	وساسد	. Lucy Lund	2001	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** 13, Patricia Byrne Fleming 11:30 A.M Arpil /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 762 Everist Drive Aberdeen Harford Baltimore, Maryland 21215-0036 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 147671932 218-26-1625 1 M 2 V 76 Director Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Harford Aberdeen Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 762 Everist Drive 21001 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ★No 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail carrier U.S. Postal 12 Ith and Mental Hve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Byrne Lillian Lewis Pages 1 and 2 should Inent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Fleming (Daughter) 762 Everist Dr. Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gdns. 4/18/09 5 Other (Specify) Aberdeen, Maryland 21. Signature at Funeral Se 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive pailmonary discourse 15 years /Medical Due to (or as a consequence of): **Examiner** Roctect 8 years CONCOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nodules - 2 years 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s 1∐ Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

State Registrar DHMH 17 Rev 1/2001

DI

24 hours after death • Funeral Director: filled in by the

within 2

6 Could not be determined

APR 20 2009

3 Suicide

29a, Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Browner, MA

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Bay view

29c. License number

00098893

Medical Conter

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Baltonore, MA

14 April 2009

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hep Kins

MA

and manner stated.

Johns

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Browner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 11:30 A M Kay Gray Frances April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick 333 Bay Avenue Calvert Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Min. Months Davs Hours 1□ M 2□ F 70 Pennsylvania Director Oct. 10 1938 220-38-1359 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Eveniner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Maryland Calvert Prince Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Bay Avenue 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married _{Speci}yhite Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence B. Coburn Helen Alice Johnston ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Gray, Jr.- husband 333 Bay Ave Prince Fredercik MD 20678 20b. Place of Disposition (Name of Centeral Cemetery April 4 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Barstow Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee BRausch 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and reley filled in by the funeral director, page 2 should be detached for use as the burta-fransit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 mont Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Dependent Di 1 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? **Division** 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 4 - 2 - 200729c. License number 29b. Signature and title of certifier Allenden 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) HOSP. RD. PRINCE FREDERICK MJ 20678 MUNSHI M.D ANWAR 31. Date filed (Month, Day, Year) 32. Registra's Signature State barked APR 03 2009 > Deneva Registrar

of Vital Records.

Amended # 5, MLU Per: FD. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03/23/09, Allegany, Co. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Garlit Melvin 1840 M 2009 0 **2**5 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegan WMHS- Memorial Campus -umberland 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Director 222-07-6771 97 August 01, 1911 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Director Maryland Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 Mel's Road 21532-Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Specify: ģ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) brick manufacturer brick layer 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) George William Garlitz Annie Missouri Robison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arzona Keefer 21532daughter 106 Mel's Road Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 24, 2009 4 Donation 5 Dother (Specify) Finzel Emmanuel Methodist Cemetery Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Toku 1. Kwis Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rosep disease or condition resulting in death) /Medical (or as a consequence Examiner Sequentially list conditions, if any leading to himodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed iabetes To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗆 Yes 2 🔀 N 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 person who completed cause of death (Item 23a) (Type, Print) Name and address Ave. Cumberland, MD. 500 Memorial lkins M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12:15 2009 Heather Michelle Groht April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 27530 Birch Manor Circle **Mechanicsville** Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 19,1972 Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours 215-88-9204 36 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 💟 No Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 27530 Birch Manor Circle 20659 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Brady Hidey Renee Sharon Morgan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27530 Birch Manor Circle, Mechanicsville, Maryland 20659

April 8,2009

20c. Location - City or Town, State

Bushwood, Maryland

Physician /Medical 1 - For State Registrar

10a, State

Director

Funeral

2

Be Completed

ပ

19a. Informant's Name/Relationship (Type. Print)

Renee Sharon Hidey / Mother

4 ☐ Donation 5 ☐ Other (Specify)

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan, M.D. 31. Date filed (Month, Day, Year)

APR 0 7 2009

20a. Method of Disposition

Physician

/Medical

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be multified at once.

Examiner

ed by the a

law requires that the death certificate be executed

Hospital or Attending Physician: The

24 hours a within 2

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Licens	see /	22. Name and Address of Facility Mattingley-Gardiner Funeral Home,						
	Michael F.	Garolines	P.O. Box 2	70, Leonardto	wn, Maryl	and 206	550		
	23a. Part / Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)						App Inte Ons	roximate rval Between set and Death	
icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence	ne bu		r.				
ysician/iwed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23	23d. Date of delivery Month Day Year						
ed by ri	Part II. Other significant conditions of		tobacco use Yes 2. ☑	e contribute to the ca No 3□ Probably					
Complete	anaen	na,		24a. Was auto perfe 1 □ Yes	psy prmed2				
ט	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only	опе)			
2	1 ☐ Yes 2 ☐ ¥6	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA	Other: 4 Nursing H	lome 5 Res	dence 6	Other (Specify)		
ation:	27. Manner of Death 1		me of 28c jury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe	3d. Describe how injury occurred			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, o	28f. Location City or To	Street and wn, State)	Number or Rural Rou	ute Number,		
ancai			sician: To the best of my knowledge, death occurred at the time, date and place, and due to the c ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, d and manner stated.						
INIC	29b. Signature and title of certifier	Daluz 1	WZ M·D 29c. License number D D D D D D D D D D D D D D D D D D D				signed (Month, Day,	Year)	

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery

State

Registrar

26840 Point Lookout Road, Leonardtown, Maryland 20650

		Please Type or					•	•	
	-	For State Registrar	of Maryla	•	artment of F <i>rtificate of I</i>	lealth and M Death		0.00	0 10516
		Registrar 1. Decedent's Name (First, Middle, Last)			Timeate of i	Jean	2. Date of Dea		3. Time of Death
Physicia /Medic		RITH GIL	LES	PIE	3		Amonth il	2 200	
Examin		4a. Facility Name (If not institution, give street and r	number)	0110		Location of Death		4c. County of De	
Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday,	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birtl		irthplace (State or Foreign Country)
Director		220-74-9750 1 □ M 2 F Usual Residence of Decedent		99 Yrs.	Months Days	Hours Will.	8. Date of Birtl (Month, Day 11/22/1	.909	MD
yland		10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
he Mai	Director	MD Anne Arundel		Glen Bu				10g. Citizen of What (1 ☐ Yes 2 No
3a or 3		584 Nolview Ct.			10f. Zip Code 210)61		United :	
death	Funeral	11 Marital Status 12. Was De	ecedent Ever in Forces?	U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian,
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dies! Ex. mither must be redified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, If Yes, Year or	s 2 X ∏No Give		1 □Yes 2 No	Specify:			hite
72 hou natura	Completed t	15. Decedent's Education (Specify only highest grade complete.	d)	(Give	edent's Usual Occup	during most of worki	ina	16b. Kind of Busines	
filed within Hygiene. other than "	du	Elementary/Secondary (0-12) College	(1-4or 5+)	life.	DO NOT use retired	d)		Mill	
filed \\ I Hygis other	Be Co	17. Father's Name (First, Middle, Last)		ГС	CCOLY WOI	18. Mother's Name	(First, Middle,		
2 should be and Mental Is marked or aumatic ev	To B	Oliver Stonesifer				Annie Ca	atherine	Myers	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinations to conferm any injury or other traumatic event, the Modical Examinations to conferm any injury or other traumatic event, the Modical Examinations to conferm the modical examinations and the modical examinations are presented as a confermation of the modical examinations and the modical examinations are confermed as a confermation of the modical examinations are confermed as a confermation of the modical examinations are confermed as a confermation of the modical examination of the modical ex		19a. Informant's Name/Relationship (Type. Print) Catherine M. Kruger-dau	ahter		ing Address (Street Nolview			r, City or Town, State	
s 1 and of Health Item 27		20a. Method of Disposition	20b	. Place of Disp cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
Pages tment of tant: If Its jury or o		1 Burial 2 □ Cronation □ Removal fro 4 □ Donation 5 ☑ Other (Specify)	m State I	orraine	Park	04/0	07/2009	Woodlaw	•
permit Depar Impor any in		21. Signature of Funeral Service Licensee	H01411	2	2. Name and Addre	ss of Facility Harı Solumbia I	cy H. Wi	tzke's Fa	mily F.H. Inc
		23a. Part I. Enter the disease, or complications that shock, or heaft failure. List only one cause or	t caused the de	ath. Do not er	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ach	exio	_				Onset and Death Weeks
Examiner		Due	to (or as a cons	equence of):					
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law re has be e 2 sho	Completed						24aWas autop	sy prior t	autopsy findings available o completion of cause of
		25. Was case referred to medical				26. Place of Deat	1 Yes	2 No 1 Y	
8 8 5	o Be	examiner? Hospital:	☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	or:		lence 6 ☐ Other (S	pecify)
ine line	ion: T	1 ■ Natural 5 □ Pending (M	ite of Injury o <i>nth</i> , <i>Day, Year)</i>	28b. Time of Injury	Wor	ry at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
Attending r death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	ice of Injury - At	home, farm, st	reet, factory, office			Street and Number or	Rural Route Number,
ital or irs afte ral Dir	Cert	4 Hornicide	ilding, etc. <i>(Sp</i> e				City or Tow		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director, e completely filled in by the fu	Medical	29a. Certifier (Check only one) 1							
To the within the complex comp	M	29b. Signature and title of certifier	~ (RW	29c. Licens	se number		29d. Date signed (Mo	
5)02		30. Name and address of person who completed ca	ause of death (It	tem 23a) (Type	Print) NP 16 F	Tests.	Aira	April 3 Boellon	21228
Sta	-	31. Date filed (Month, Day Year) 32 APR 06 2009	. Pegistrar's sig	nature	1 .	LOUIN ?	MUE.	unn	W
Registr	ar	MFR U 0 2009	Breva	B. A	acked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iui			1- For State Certificate of Death Registrar Certificate of Death		.No. 20	09 1254
	Physicia	ın/	1. Decedent's Name (First, Middle,Last)	Date of Death	Dav Year	3. Time of Death 0217 hrs
vie:	dical Exami		Marisa G. Godwin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	April 6, 200	9 4c. County of Dea	
			4223 Oglethorpe Street Hyattsville		Prince Geor	
	Funeral Director		Months David House Min	8. Date of Birth Jan 11,	(MM/DD/YYYY) 9. E	Birthplace (State or eign Country) C A
-		-	546-06-3221	Jan II,	1930	Southly) (A
	w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
3	Aaryland 28a-f show Latonce.	햦	MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	1 X Yes 2 No
1	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	I Director	4223 Oglethorpe Street 20781		ISA	
	eath wit items 2 ust be n	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 Married 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri		White, etc	
	after dans, or	by Ft	3 Widowed 4 X Divorced or Dates: Unk 1 Yes 2 X No specify:		Specify: Wh	ite
	hours afte 'natural", Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired		16b. Kind of Busines	is/Industry
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of I teath and Menial Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.	Completed	Teachers Aide		Education	Ĺ
	21215-0036 uld be filed within 7 Mental Hygiene. narked other than c event, the Medica				,	
	2121 Jid be f Mental marker event.	To Be	Santi Sebastian Martorano Nancy Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur			ate. Zip Code)
	ages I and 2 shount of Health and I		Tina C. Orro/sister 2514 Whitewood Drive Sa			
	ore, Nest and Street Health	Ī	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
	Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 Other Specify: W. Arundel Crematory 04/	13/09	Odenton,	
	Balt permit. Departi Import		21. Signature of Funeral Service Ligensee Auto MO1251 Beverly L. Heckrotte			
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and
	/Medical `xaminer		Immediate Cause (Final disease a Alcohol and tramadol intoxication			Death
			b			
		iner	Sequentially list conditions, if any, leading to immediate besset. Enter Uncorpting Cause			
	- i	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	760, icate be executed physician and the burial - transit		MENDED 23a,P11,27,28a-f,perME, g890 4/	22/09 1	T	
	60, ate be e thysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	very
	Sox 687 Jeath certific e attending p for use as th		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	СУ	Month	Day Year
	Box 687 e death certific the attending ed for use as the	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
	P.O. B s that the d gned by the e detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	-		to the cause of death?
	ds, P.C quires that en signed I uld be deta	Completed by	Cirrhosis of liver; upper gastrointestinal	24a. Was a		Probably 4 Unknown autopsy findings available
	cords,	nple	bleeding	autops	y prior t	to completion of cause of
	tal Rec		25. Was case referred to medical 26. Place of Death (Check on	1 Yes 2	No 1 🗸	Yes 2 No
	n of Vital I ling Physician: After this certifi funeral director,	To Be	examiner?		Residence 6 🗸 Ot	her: Scene
	Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been siled in by the funeral director, page 2 should be		1 Natural 5 Dandies (Month, Day, Year)	8d. Describe h	ow injury occurred	
	ivisior or Attend after death Director:	icati	2 Accident Investigation FQ 4/6/09 FQ 2:12 am 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2:		treet and Number or	Rural Route Number, City
	Div	Certification:	single family home	or Town, St. yattsvi	_{ate)} 4223 Og 111e, MD	Rural Route Number, City Slethorpe St
	Division of Vital Records, P.O. Box 68760, within 24 hours after death Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dignes 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.			
	To Witl	Mec	and manner stated 29b. Signature and title of certifier 29c. License number		29d. Date signed (i	
			Caric Haccar O.C.M.E.		April 6, 2009	
(241/42		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
Ì		ate				
	Regist	21	p. pourse			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Ella E. Hopkins 2009 12:22 March 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) July 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country) Maryland Days 1 □ M 2 🗗 F 77 1931 217-28-2005 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the local Experience in usi be notified at 1 ☐ Yes 2 No Director Mitchellville Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20716 18210 Central Ave. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status i filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 Is marked other than College (1-4or 5+) National Security Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Haas Oscar Entzian ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) husband 20716 18210 Central Ave. Mitchellville, MD David Donald Hopkins, Sr. permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 1 once. 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, MD 4/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death. 23a. Pw 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Immodia disease or condition resulting in death) Ulmonar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-trar Due to (or as a consequence of): attending physician for use as the buria that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 2VZNo signed by the a d be detached f Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ens autopsy performed certificate 1 ☐Yes 2 ☐No Per 1 ☐ Yes 2 1 No of or Attending Physician: after death. 25. Was case re rre to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification; To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and a dress of purson who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Men 03/2	ded # 20 4/09, A) c	, MLU, Per: FH Plea gany CO.		t in Black II						105	10
			For State Registrar	State of Ma		ertificate of			Reg. No.	003	125	43
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ath Day	Year	3. Time of Dea	ath
	Physicia /Medic		REBECCA GERTI	RUDE KIMBLE				03	19	09	2142	М
The same	Examin	er	4a. Facility Name (If not institution				r Location of Death			nty of Death		
and the	-		WMHS Braddock 5. Social Security Number		(In yrs. last birthda	Cumbe:	If Under 24 Hrs.	8. Date of Bir	th	11egany	ace (State or Fo	oreign
	Funeral Director		182-22-7530	1□ M 2🌠 F	85 Yrs.	Months Days	Hours Min.	(Month, Da 11/26/	1923 WEST VIRGINIA			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location				10	d. Inside City Li	imits
:	Maryii Fisho	tor		NERAL	FORT A	ASHBY					1 □ Yes 2]	∑ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and to redified at once.	Il Director	10e. Street and Number MAPLE LANE			10f. Zip Code 267.	L9		10g. Citizen of What Country? U.S.A.			
	r death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.			
036	urs afte al', or i Examin	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	lo	1 □Yes 2 X No	Specify:		Specify: WHITE			
215-0036	"natur	Completed	15. Deceden (Specify only highe	nt's Education st grade completed)	i (Giv	cedent's Usual Occupie kind of work done DO NOT use retire	during most of work	ing	16b. Kind o	f Business/Indi	ustry	
212	within liene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	+) 1	MANAGER 8	•		RETAI:	L GROCE	RY STOF	RE
nd	tal Hyg a other	BeC	17. Father's Name (First, Middle,	. '			18. Mother's Nam		, Maiden Surr PROPS	*		
Maryland	d Men narke	은		OWERY	105 140	iling Address (Street					Cadal	
Z	nd 2 st alth an 27 is r r traur		19a. Informant's Name/Relations FRANCES G. PA			45 NORTHS						
altimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removel from State	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Locatio	on - City or Tov	vn, State	
ţ;	rt. Pag rtment rtant: I njury o		4 □ Donation 5 □ Other (S	Specify)		BY CEMETE		/2009		ASHB	Y, WV	
Bal	Depar Impor any ir		21. Signature of Funeral Service	Licensee has had	11-	UPCHURCH	FUNERAL 1260, FO	HOME, I	NC.	26719		
			23a. Part 1. Enter the disease, or	r complications that caused tonly one cause on each lin	the death. Do not e					Ť	Approximate Interval Betwee	en
F	hysician		Immediate Cause (Final disease or condition	5	CPS/S	5					Onset and Deat	ath
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	411 51	grud	du	1 tile	ditis	Jwe	2010
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		à consequence of).		,, ,			5-1110		
	executed n and al-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
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Box	ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnan			23d.	Date of delive	ry Day Yea	ar
P.O.	y the a	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 ☐ Other (specify) _						
ds, P	irres that the death certificate be exisigned by the attending physician doe detached for use as the burial	by Physician/Medical	Part II. Other significant condition to the factoric	ons contributing to death but	ut not resulting in the	underlying cause gi	ven in Part I.		_		e cause of deatl ably 4 ☐ Unki	
COL	s been si should I	Completed	Chronic o		,			24a. Was		4b. Were autop	sy findings avai	ailable
_ Be	trending Physician: The law death. ctor: After this certificate has y the funeral director, page 2 s	Somp	differse					auto perfo 1 □ Yes	ormed?	prior to con death? 1 ∐Yes	npletion of caus 2 □Ma	se of
/ita	cran: sertific setor,	Be	25. Was case referred to medica examiner?			100	26. Place of Dear	th (Check only o	one)			
o	Physi this cr	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 The patie		IEIII 3 LI DOA		ome 5 Resi)	
o	th. : After : funer	tion	1 Natural 5 □ Pendir			y Wo	rk?]Yes 2 □No	zed. Describe	now injury oc	ouricu		
Division of Vital Records,	or Atter after dea Director	Certification: To	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, c. (Specify)	street, factory, office			Street and No wn, State)	umber or Rural	Route Number,	r,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	f examination and/or	eath occurred at the rinvestigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	e cause(s) and , date and pla	d manner as st	ated. the cause(s)	
	id o'm	M	29b. Signature and title of certifie	mu W C	Un	29c. Licen	se number			gned (Month, L	Day, Year)	9
OKE	1. 1.		30. Name and address of person	who completed cause of d	eath (Item 23a) (Typ	e, Print) HOW C	1/142	ant	1/10	-06	NU	
	Sta		31. Date filed (Month, Day, Year)	4 2009 32. 9egistra	ar's Signature	1		-				
DIN	Registr		HAL S.	I LUUT Masses	1. D. X	parker				·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygi

			State of Maryland 1 - State Amend #27, perME g891 5/15/09	Department of Dertificate of	⊓eaith and i f <i>Death</i>		eg. No. 2 A A Q	12550							
П	- 1.		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death							
	Physicia /Medic		LILLIAN ELIZABETH KLAVUH	.N		04	05 2009	0610 M							
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death		4c. County of Death								
4'			Nemorial Hospital	birthday) If Under 1 Year	berlander 24 Hrs.	O Data of Birth	HLLEGO								
	Funeral		5. Social Security Number 6. Sex 0 7. Age (In yrs. last	Yrs. Months Days		8. Date of Birth (Month, Day, 03/30/19	Year) 9. Bythp								
	Director		214-05-7922 93 Usual Residence of Decedent			03/30/19	016 MARY	LAND							
	yland Now		10a. State 10b. County 10c. City, T	own or Location			10	d. Inside City Limits							
	a-f sl	ctor	MD ALLEGANY FRO	OSTBURG				1 □Yes 2√ No							
	or 28	Director	10e. Street and Number	10f. Zip Code		10	0g. Citizen of What Coun	try?							
	ath wi		100 HONEYSUCKLE LANE, APT. 203	21532			U.S.A.								
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Io- 14. Race - American Indian, Black, White, etc.								
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 □Yes 2 X No	Specify:		Specify: WHI	ਧਾਸ							
15-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Modical Examinar must be maiffied at		15. Decedent's Education 1	 6a. Decedent's Usual Occi	upation		16b. Kind of Business/Inc								
212 2	in 72 in "ne Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retir	e during most of work ed)	ing									
7		Som	1	BOOKKEEPEI	R		BANKING								
2	be filed ital Hygi d other event, I	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Maiden Surname)									
<u> </u>	Mer Mer arke	၉	ARTHUR F. LOTTIG				BETH EDENHAR								
Maryland	C1 = E			19b. Mailing Address (Stree 2001 NORTH 1				Code) 85541							
	1 an Heal em 2		STEPHEN KLAVUHN / SON 20a. Method of Disposition 20b. Place				20c. Location - City or To								
و	e = 5			e of Disposition (Name of etery, crematory or other place of CREST MEML.			CUMBERLANI								
Baltimore,			4 □ Donation 5 □ Other (Specify) HILLA 21. Signature of Funeral Service Ucensee	22. Name and Add	ress of Facility			, MD							
ğ	permit. Departi Importa any inji		Clared D Josephilic	UPCHUR	CH FUNERAL		P.A. ERLAND, MD	21502							
Н			23a. Part 1. Enter the disease, or complications that caused the death.					Approximate Interval Between							
-	Physician		Immediate Cause (Final disease or condition a. Caula publication and the condition a												
	/Medical		resulting in death) Due to (or as a consequent	ice of	infa of										
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	ed sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ce of):	0		1	1 /							
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			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of delive	ry							
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Ś.	vician: The law requires that the di certificate has been signed by the rector, page 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause g	given in Part I.		acco use contribute to th								
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o	Attending Physician: r death. sctor: After this certific by the funeral director,	2:10	27. Manner of Death 28a. Date of Injury 28	Bb. Time of 28c. Inj	4 LI Nursing He	28d. Describe ho	nce 6 ☐Other (Specify w injury occurred	<u>//</u>							
0	nding th. :: Afte	tio	1 Natural 5 Pending (Month, Day, Year) 2 Naccident investigation 04/03/2009		ork? □Yes 2 ∑X No	patient	fell at hom	ie							
DIVISION	Atte	ific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)		е		reet and Number or Rura , State) 100 Honeys								
בֿ	tal or rs afte al Dir ed in	Certification:	At home			Apt. 203,	Frostburg, MD	suckte rare							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only (C												
	the I thin 2 the I mplet	Medi	one) and manner stated.		nse number		9d. Date signed (Month, I								
			29b. Signature and title of certifier	250. 200			4/1/10	/,/							
	2	1	30. Name and address of person who completed cause of death (Item 23)	3a) (Type Print)	006610	/	7/0/0/								
	- 0		ABAH HANAN CHEENA.	900 SETON	V De C	MM NA	MAND M	7 21502							
H	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	9		111									
	Registr	ar	APR n g 2000 A	6.11											

09-02851 Mich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

Michael Kirouac	1-	For State	Stat	te of Maryland	/ Depart	ment of ficate of	Health and Death	i Mentai r		eg. No.	201	19 1	255
Physician	Re	gistrar Decedent's Name	e (First, Middle,I	Last)					2. Date of Dea Month	Day Y	ear	3. Time of Deat 2240 hrs	th
Medical Examine	er	Michae	el Kiro	uac			b. City, Town, or I	anation of Dog	April 9, 20		y of Death		—
	4:			give street and number	r)	4	b. City, Town, or i Bowie	Location of Dea	201		George's	s	
	5	12741 Midw Social Security N		. Sex 7. A	ge (In yrs. lasi	t birthday)	If Under 1 Year			rth (MM/DD/YY)	Cour	nplace (State or ntry)	1
Funeral Director	- 1	214-70-0		1 X M 2 F	54		Months Days	Hours N	^{(lin.} 02/27	/1955	Mas	sachuse	etts
	1_	sual Residence o										10d. Inside Cit	y Limits
any	_	0a. State	10b. County		,	own or Location	on					1 X Yes 2	
and Street		MD		George's	Bo	owie	10f. Zip Code			10g. Citizen of	What Coun	try?	
the Maryland as or 28a-f show atified at once.	Ulrector	0e. Street and Nu		Tono			20715			USA			
23a o notifi		12741 M	Idwood	12. Was Decede	nt Ever in U.S	. 13. Wa	s Decedent of His	panic Origin?	(Specify Yes or N		ace - Americ	can Indian, Blad	ck,
ath wi	ੜ । `	1 X Never Marr	ied 2 Mai	rried Armed Force	s? 2 No	lf Y	es, specify Cubar		erto Rican, etc.)				l
fter de	되	3 Widowed		rced If Yes, Give Year 1	975–76		Yes 2 X No		of work done	Special Specia		White_	
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-00% J withi giene ther the	탉	17. Father's Name		Last)				18.Mother's N	ame (First, Middle	, Maiden Surna	ime)		
215 be file oral Hy ked o	<u>e</u>	Edmond	L. Kirc	ouac			(8)	Patr	cicia N. or Rural Route N	Ganey	Town, State	Zip Code)	
	岭	19a. Informant's N							Ct. Ranc				0
ME sind 2 si alth ar alth ar ann 27	-	Sandra 20a. Method of Di		ouac/sister	20b. F	Place of Dispo	sition (Name of co		Date	20c. Locati	on - City or	Town, State	
Ore, ges la of He of He		1 Burial 2	XCremation	3 Removal from	State	rematory or o			/14/2009	Balt	imore	MD	
timent rements	}	4 Donation 21. Signature of F	5 Other Sp	ecify: Licensee	_ Ba	22.	Cremator Name and Addres	ss of Facility	/ <u>14/2009</u> Beall Fi	neral :	Home		
Bal permi Depa Impo	- 1	1/2:	0//	5			6512 NW	Crain I	Hwy. Bo	owie, M	D 20	715 Approximat	te Interval
Physician		23a. Part I. Enter	the disease, or	complications that cause on each line.								Between O	Onset and
'Medical kaminer		Immediate Cause	e (Final disease	_{a.} Hyperte			scleroti	lc card	<u>iovascul</u>	ar dise	ase	-	
tammer		or condition resu	Iting in death)	Due to (or as a co	onsequence o	t):						4	
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760, cate by physic the bu	/Me	IF FEMALE: 23b. Was decede	ent pregnant in t	he 23c. If yes, ou			Fetal death	3 Ectopic p	regnancy	Moi		Day	Year
certification	cian	past 12 mon	ths?	4 Pregna	nt at time of de	-	Other (Specify)			-			
ords, P.O. Box 68760, v requires that the death certificate be easheen signed by the attending physicia should be detached for use as the buria	Physician/M		No 9 Un			ting in the	e underlying caus	e given in Part	1. 23e. D	id tobacco use	contribute t	to the cause of	death?
P.O. ss that the gned by e detache	by P	Part II. Other si	gnificant condi	itions contributing to	death but not	resulting in the	e underlying cada	ic givon in a are	1	Yes 2 No	o 3 Pr	obably 4 🗸	Unknown
S, P quires t an sign	ted									Vas an lutopsy	24b. Were	autopsy finding o completion of	s available f cause of
cord law rec has bec	Completed									erformed?	death?	?	No
Rec The cate	င္ပ	25. Was case re	formed to modic				26.PI	ace of Death (0	Check only one)				
/ital F ysician: his certifi director,	Be	examiner?		Linenital:	npatient 2	ER/Outpation	ent 3 DOA	Other ₄	Nursing Home 5		e 6 🗸 Oth	ner: Scene	
of Vit ing Physic After this	7. To	1 Yes	2 No Death	28a. Date (of Injury Day,Year)	28b. Time	, ,	Injury at Work?		ribe how injury	occurred		
ision (Attendin rate death.	ţi	1 X Natural 2 Accider		nding				Yes 2		ion (Street and	Number or	Rural Route N	umber, City
Division of Vital lat or Attending Physician. To after death. **All Director: After this certiled in by the funeral director.	ifica	3 Suicide	6 _ Co	uld not be 28e. Place	e of Injury - At	home, farm, s	treet, factory, offi	ce building, etc	or To	wn, State)	(tambor or		,
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicie	de	remined (Specify) Physician: To the bes	t of our less stude	adao death or	curred at the time	e, date and plac	ce, and due to the	cause(s) and r	nanner as s	stated.	
he Ho: in 24 he Fu	ledical	29a. Certifier (Check only one)	✓ Certifying ✓ Medical Ex	caminer: On the basis of	of examination	and/or invest	igation, in my opi	nion, death occ	curred at the time,	date and place	, and due to	the cause(s)	
To t with To t	Med	and manner stated. 29b. Signature and title of certifier 29c. License number									ite signea (i	Month, Day, Yea	ar)
	~	Day	1619	rethad or	25)		0	.C . M.E.		April '	10, 2009		
				on who completed caus	se of death (Ite	em 23a)	444 D 01	root Daltim	Dre, MD 2120	11			
C#541		Pamela	E. Southall,	MD Assistant	Medical Ex	kaminer	111 Penn St	reet, Baitim	UIE, IVID Z IZC				
Regi	stat	•	Month, Day, Yea		egistrar's Sign	A. A	rans						
DHMH 17 Rev 1			71114			ORIGI				OCME			

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and

			delible lnk. Ensure	-	
	For State of Ma	,	artment of Health and rtificate of Death		ene g. No. 2009 2552
Physician (Madical	1. Decedent's Name (First, Middle, Last) James Arthur Lowry, S	r.		2. Date of Death Month April	Day Year 3. Time of Death 1, 2009 4:45 a
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 3604 King Drive 5. Social Security Number 6. Sex 7. Ag	ne (In yrs. last birthday)	4b. City, Town, or Location of Dea Dunkirk If Under 1 Year If Under 24 Hrs Months Days Hours Min	s. 8. Date of Birth (Month, Day,	4c. County of Death Calvert 9. Birthplace (State or Foreign Country)
vith the Maryland or 28a-f show be notified at opposite the notified at opposite the notified at the notified	578-20-1468	84 119.	Dunkirk	8/22/1	924 DC 10d. Inside City Limits 11 Yes 2 No g. Citizen of What Country?
urs after death value all, or items 23a sominat must	3604 King Drive 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 ☒ Yes 2 □ 1 Yes, Give Year or Dates:	No	20754 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2X No Specify:	Specify Yes or Norto Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
filed within 72 hou Hygiene. other than "natura ent, The Mudeal E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	(Give	rdent's Usual Occupation kind of work done during most of wo DO NOT use retired) t Vendor 18. Mother's Na		6b. Kind of Business/Industry Sales aiden Surname)
and 2 should be file afth and Mental H atth and Mental H 27 is marked other traumatic even	Robert Bruce Lowry 19a. Informant's Name/Relationship (Type. Print) James Lowry, Jr./Son		Erma Song Address (Street and Number or F		
permit. Pages 1 a Department of He Important: If item any injury or oth	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sureral Service Licensee	Chelter		10/09 C1	neltenham, MD Wood F.H., P.A.
eath certificate be executed attending physician and for use as the burial-transit area. Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C	d the death. Do not en			st, Approximate Interval Between
nat the death certificate to do by the attending physic etached for use as the by Physician/Medica		2 ☐ Fetal death 3 [☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
: The law requires that cate has been signed to page 2 should be dett	Part II. Other significant conditions contributing to death be a contributi	out not resulting in three	underlying cause given in Part I.		
certifi ector	27. Manner Death 1 Death 5 Pending 28a. Date of Injugatural 5 Pending	ent 2 ER/Outpatie ury ay, Year) 28b. Time o	of 28c. Injury at Work?	perform 1 Yes 2 eath (Check only one	ed? death? No 1 Yes 2 No) nce 6 Other (Specify)
oital or Attending Phys urs after death. real Director: After this iiled in by the funeral dir Certification: To	4 Homicide determined building, el	jury - At home, farm, st		City or Town,	
To the Hosp within 24 hou To the Fune completely fill Medical	29a. Certifier (Check only one) 1 □ CertifyIng Physician: To the best 2 □ Medical Examiner: On the basis of and manner st and title of certifier	of examination and/or in ated.		curred at the time, da	and place, and due to the cause(s) and Date signed (Month, Day, Year)
541	30. Name and address of person who completed cause of ANWAR MUNSHIM. D. 54	Physic death (Item 23a) (Type, at 303 11	- D 19427 Print) O HOSP RD. PRI	NCE FREDO	4/2/2009 ERICK MD 20678
State Registrar MH 17 Rev 1/2001	31. Date filed (Month, Day, Year) 32. Registr	Penewa S.	Spares		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registra 2553 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:30PM **Physician** Laing Louise Anna /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland 12558 Willowbrook Road 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 20, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 2□¥ 217-14-4465 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count 10a. State permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I a Medical Eva. inst., ust be notified at once. Allegany MD Cumberland 1 □ Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 12558 Willowbrook Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 □Yes 2 □No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: white 3 → Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farm owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Donahoe Marie O'Neal Donahoe ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Mt. Olney Lane Olney MD 20832 19a. Informant's Name/Relationship (Type. Print) Anthony Laing son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter and Paul Cemetery 4/2/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ral Home, PA 21. Signature of Functal Service Ucense-108 Virginia Avenue: Cumberland, MD 21502 Approximate interval Between Onset and Death YTS complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the shock, or heart disease. ause on each line Immediate C i se (Final disease or andition resulting in death) Arteriosclerotic heart disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off: Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2√2No 9 □ Unknown s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has rector, page 2 s autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \sum Nursing Home Hospital: Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 ☐ Accident 5 Pendina 1 ☐Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: of completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 3 1 2009

nas

4

and address of person who completed cause of death (Item 23a) (Type, Print)

124

32. Registrar's Signature

D09157

ST.

RD

March 30 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last 1:30 AM **Physician** artho /Medical 4a. Facility Name (If not institution, give street 4c. County of Deat Examiner evena everna a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7, Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 X F SEPTEMBER 17,1916 PENNSYLVANIA 184-14-6795 92 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exertified at 1 ☐ Yes 2 1 No Director SEVERNA PARK MARYLAND ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with UNITED STATES 21146 24 TRUCK HOUSE ROAD Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: WHITE Š 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/ th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MELANIA DVORAK PANTELEIMON ZURAW ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 1378 LITTLE JOYCE LANE, ARNOLD, MARYLAND 21012 DENISE L. HERSHBERGER/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition APRIL 11 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 MONONGAHELA, PA MONONGAHELA CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Lice Will Erous M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** meumoure disease or condition resulting in death) /Medical Examiner divanc Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 Z No Day 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown þ signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy The perforn certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Mont) Registrar

DIANA

30. Name and address of person who completed cause

NG

Truckhouse

of death (Item 23a) (Type, Print)

eurna Park MD 21146

Amend #8,19 CCHD, 4/6/0	47,per FD, Plea	se Type or Pr	rint in B	lack In	delible	lnk.	Ensu	re Al	l Copies	s Are	Legible	÷.	
	1 - For State Registrar	State of N	Maryland	d / Depa	artment rtificate	t of F	lealth a	and M	lental Hy	/giene Reg. No	200		555
Physician	1. Decedent's Name (First, Middle Harold Lawrence								2. Date of Do	Day	y Ye		
/Medical Examiner	4a. Facility Name (If not institution Harford Memoria	n, give street and number			Havi	re D	r Location o	ce	March	4c.	County of Darford		
Funeral Director	5. Social Security Number 219–48–8575	6. Sex 7. XX M 2 □ F	Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	71 94 (9. M	Birthplace (State o Country)	r Foreign
/land	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					194	+ /	10d. Inside Cit	
8a-f sh	MD Harfo	rd	Hav	re De								1 □Yes	2 X No
a or 2	10e. Street and Number 508 N. Juniata	Street	Apt. 2		10f. Zip					10g. Cit	izen of What SA	Country?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Execution of the motified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2□ Mar	12. Was Decede Armed Force 1 X Yes 2 I	^{s?} n 19 68		Was Deced fYes, spec 1 □Yes 2	ify Cuba	lispanic Ori an, Mexican Specify:	gin? (Spe n, Puerto	ecity Yes or N Rican, etc.)	0-	Black, W	merican Indian, hite, etc.	
-003(hours a ntural", o	3 ☐ Widowed 4 █ Divorced	Year or Date	s: 1972	16a. Dece	dent's Usua	l Occup	ation			16b. K	ind of Busine	White ss/Industry	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours attended to Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or y injury or other traumatic event, the Medical Exercite. To Be Completed by F	(Specify only higher Elementary/Secondary (0-12)	St grade completed) College (1-4c	or 5+)	(Give life. I Polic	DO NOT us	e retired	,	t of workii	ng	P. C Gove	c. G. County overnment		
yland uild be file Mental Hy arked othe attic event,	17. Father's Name (First, Middle, William J. Mas								(First, Middle e Dawse		Surname)		
Mary d 2 sho lth and 17 is ma traums	19a. Informant's Name/Relations Kathleen Estep			1	-				al Route Num rdeen ,	_		e, Zip Code)	
ore, of Heal fitem 2	20a. Method of Disposition 1 □ Burial 2 🏋 Cremation		20b. Pl	ace of Dispo)ate			or Town, State	
Itimo	4 □ Donation 5 ☑ Other	(pecify)	Lee	Crema	tory		1	2,2	009		inton,	MD	
Bal permi Depa Impo any Ir	21. Signature of Funeral Selfure	MO1464 John F	. Holm	es 81	.25 Sc	outh	ern M	'Lee aryl:	Funerand Bl	al Ho vd. (me Ca Dwings	lvert. P. , MD 2073	A. 36
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In mediate Cause (Final												
Physician /Medical	isease or condition resulting in death) a. Due to (or as a consequence of):												
Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to	as a consequ	of Co	20	a	_					100	
xecuted and l-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	·										
ш е е е е	resulting in death) Last	d.	as a consequ	ence ot):									
Box 68760, eath certificate be e attending physician for use as the burla cian/Medical E	IF FEMALE:	23c. If yes, outcome	me at praena	201									
of Vital Records, P.O. Box 68760 Physician: The law requires that the death certificate be r this certificate has been signed by the attending physicia ral director, page 2 should be detached for use as the bur	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birt	th 2 ☐ Fetal nt at time of de	death 3 [☐ Ectopic pi ☐ Other <i>(sp</i>		У			;	23d. Date of Month	,	ear/
IS, P. es that es that igned be deta	Part II. Other significant conditi	ons contributing to deat	h but not resu	Iting in the u	nderlying ca	ause giv	en in Part I.					e to the cause of d	
Corc	Zsophage	ial las	700						1 ∟ 24a. Wa:	Yes 2		4	Jnknown available
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Vita sician: sician: certific irector, Be (25. Was case referred to medica examiner? 1 ☐ Yes 2 No		atient 2 🗆 l	EB/Outpotion	* 2 D DC	Oth	or.		(Check only		C 00th-1	2	
n of ng Phys ng Phys ther this conneral direction on: To	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of		28b. Time of Injury		8c. Injur Wor	4 🗀 NU		me 5 Res 28d. Describe			Specify)	
Division of Vital Records, To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be d Medical Certification: To Be Completed by	2 Accident investi 3 Suicide 6 Could 4 Homicide detern	gation not be 1280 Place of	Injury - At ho , etc. <i>(Specify</i>	me, farm, str	M eet, factory		Yes 2□			(Street ar own, State		r Rural Route Num	ber,
the Hospital	29a. Certifier 1 Certifyi (Check only one) 2 Medical	n g Physician: To the be Examiner: On the basi and manner	is of examinat	vledge, deat ion and/or in	h occurred vestigation	at the ti	me, date ar opinion, dea	nd place, ath occurr	and due to the	e cause(s e, date an	s) and manne d place, and	er as stated. due to the cause(s)
To the within To the compl	29b. Signature and title of certified	nona		10	290	Licens	se number	356	3	29d. Da	ate signed (M	onth, Day, Year)	9
1011 0 1 1	30. Name and address of person	who completed cause of	of death (Item	23a) (Type,	Print)	501	5,0	lnio.	S BIL	rd	יאן	31, 200 ylard	7 /
State	31. Date filed (Month, Day, Year,	J cromps 32. Reg	istrar's Signat	ure		1+0		de	Gre	لرو	/la	yland a	407
Registrar DHMH 17 Rev 1/2001	AP	₹ 0 3 2009	Denews	B.	par	Ker							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 3, **Physician** Linda Jeanette McClure 5:40 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Health & Rehabilitation Bethesda Montgomery 8. Date of Birth (Month, Day, Year) 10–01–1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 M 2 V F 216-64-6648 57 Washington, DC Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10h County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at MD Calvert Solomons 5 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20688 11450 Asbury Circle, Apt. #415 United States by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If flem 27 is marked other there any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institute College (1-4or 5+) Elementary/Secondary (0-12) Mail Clerk of Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laurence Edward Northcutt Gwen Hoke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen Hoke Northcutt (Mother) 11450 Asbury Circle, Apt. #415, Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 4/8/2009 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Advanced (disease or condition resulting in death) hrosic unknown. /Medical Due to (or as a consequence of) Examiner Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 1 Tes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After t d in by the funera Certification: 5 Pending investigation 1 🗌 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

dRW

To the Hospital within 24 hours a To the Funeral C

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day,

15216

and manner stated.

32. Registraris Signature

swan

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOWDHURY,MD;

2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DINO

DRIVE; BURTONSVILLE, MD 20866

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 For State Registrar	State of Marylan	•		of Health and of Death	_	giene Reg. No.	009	12557
			Decedent's Name (First, Middle, Last))				2. Date of De	ath		3. Time of Death
	Physici /Medio		LORETTA MA	RIE	MYER	S		Month 04	0.2	Year 2009	0831 M
	Examir		4a. Facility Name (If not institution, give	street and number)	111 111		wn, or Location of De			nty of Death	V031
-			WMHS MEMORIAL	CAMPUS		CU	MBERLAND		AL	LEGANY	
	Funeral		5. Social Security Number 6. Se	7		If Under 1 Months	Year If Under 24 H Days Hours Mi		th		lace (State or Foreign
	Director		Usual Residence of Decedent	лм 2 X Г F 94	Yrs.			03/16/	1915	Pen	nsylvania
	land		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f she	ţ	MD Alle	ranv		Cumb	erland				1 TYes 2 □ No
	the	Director	10e. Street and Number	Sarry		10f. Zip C			10g. Citizen	of What Coun	try?
	3a or		109 N. Johnson	n Street			21502		Ü	USA	
	death ms 2	Funeral		12. Was Decedent Ever in U.	S. 13. V	Vas Deceder	nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No	No- 14. Race - American Indian,		
9	hours after death with the Maryland tural", or items 23a or 28a-f show al Evan Indianal Demodified at	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give	1	r Yes, specin □Yes 21%		erto Hican, etc.)		Black, White,	etc.
21215-0036	ural",	d by	3 🕅 Widowed 4 🗆 Divorced	Year or Dates:		Lies 2X	and Specify.		Spe	cify:	White
2	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	lent's Usual (kind of work	done during most of w	orking	16b. Kind of	Business/Ind	lustry
2	be filed within 72 ital Hygiene. id other than "na event, III. Medio	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use					
2	Hygie Hygie ther int, II		17. Father's Name (First, Middle, Last)			Homen		ame (First, Middle		ome	
Maryland	should be filed within 72 hours after death with the Marylan nd Menial Hygiene. marked other than "natural"; or items 23a or 28a-f show marked other than "natural"; or items 23a or 28a-f show marked other than "ban in a natural be rediffied at matter event, the Medical Evan in a natural be rediffied at	Be c	Oscar		Maure	r	Flore		Mari	-,	Davis
<u></u>	s 1 and 2 should I f Health and Men tem 27 Is marke other traumatic	ို	19a. Informant's Name/Relationship (Ty	roe. Print)			Street and Number or				
	alth a		Joan M. Ware / Dau	· · · · · · · · · · · · · · · · · · ·	I .		nson Stree				
altımore,	s 1 a		20a. Method of Disposition	20b. F	Place of Disposemetery, cren	sition (Name	of i	Date		on - City or To	
Ē			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	rom State		•	l Park 04	10712000	C1		1 MD
a	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licens		22	. Name and	Address of Facility A	dams Fam	ilv Fur	oerian	Home P A
ñ	an In De		Kongeck	(ldag	40	4 Dec	atur Stree	t. Cumber	rland.	MD 2	1502
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the deat							Approximate Interval Between
. ,	Physician		Immediate Cause (Final disease or condition	a CORONARY AR	TEDY D	CELCE					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence)		LSEASE					
	Examiner		Coquentially list conditions								
	p .tt	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a consequent	uence of):						-
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Ď.	cian s	Ü	resulting in death) cast	Due to (or as a consequent	uence of):						
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S,	requires that the reen signed by th nould be detache		Part II. Other significant conditions cor	tributing to death but not res	ulting in the ur	derlying cau	se given in Part I.	23e. Did t	obacco use c	ontribute to th	e cause of death?
So.	w requires that s been signed I should be deta	d by	HYPERTENSION, PAR	OXYSMAL ATRIA	L FIBR	LLATI	ON	10	Yes 2 □ No	3 □ Prob	ably 4X Unknown
Hecord		lete						24a. Was	an 24	b. Were auto	osy findings available
	The la ate ha	Completed						- autor	osy rmed?	prior to cor death?	npletion of cause of
VITAI V	an: tiffica tor, pa	a)	25. Was case referred to medical				26 Place of D	1 □Yes eath (Check only o	-	1 ☐ Yes	2 🗆 No
5	Physician: this certific ral director,	To B	examiner?	lospital: 1 ☐ Inpatient 2 🛣	ER/Outpatien	1 3 □ DOA	Other	Home 5 Resi		Other (Specifi	()
	9 Ph ter th	盲	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		. Injury at Work?	28d. Describe			/
DIVISION	endir ath. or: Af	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day, rear)	injury	м	1 ☐ Yes 2 ☐ No				
<u> </u>	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	me, farm, stre	et, factory, o	ffice	28f. Location (: City or Tox		mber or Rura	l Route Number,
ָ ב	utal o urs af ral Di lled ir	Se									
:	To the hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, death tion and/or inv	occurred at restigation, in	the time, date and pla my opinion, death of	ice, and due to the curred at the time,	cause(s) and date and place	manner as s e, and due to	tated. the cause(s)
;	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner stated.		290 1	icense number		20d Date sig	ned (Month	Day Vaar)
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	nas		30. Name and address of person who co				CIIMBEDI AN	TD MD	2150	2	
	Sta	te	HUMA SHAKIL, MD 31. Date filed (Month, Day, Year)	625 KENT AVE.	ture /	<u> </u>	COLIDEKTAL	עונו פעו	2130		
	Registra	ar	31. Date filed (Month, Day, Year) APR 0 3 2009	Deren B.	park	2					

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State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Mary Mae Minnick 03 2009 1504 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ X F 87 Director 12/30/1921 <u> 232-26-5536</u> Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Marylar , or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11310 Sunny Lane 21502 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Experimenons. Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Medical Secretary Radiology Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clem Reckley Flossie Mae House ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrett Lamar Minnick / Husband 11310 Sunny Lane, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet Cem @ Rocky Gap 04/02/2009 Flintstone, MD 22. Name and Address of Facility Alams Family Funeral Home, 21. Signature of Funeral Service License 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosci /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MARCH 31, 2000 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 SETON DRIVE, CUMBERLAND M.D. 21502 VIK POONAI M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PATSY LOUISE McCABE 5:50 A.M 3, APRIL 2009 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** DEVLIN MANOR NURSING HOME ALLEGANY CUMBERLAND 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Days Hours 66 Director 214-42-2376 1/26/1942 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f shov Director 1 ☐ Yes 21 No MD ALLEGANY LAVALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 741 NATIONAL HIGHWAY 21502 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 If Yes, Give Year or Dates: Specify: U.S.A. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NATIONAL INSTITUTE al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE OF HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be (UNKNOWN) FRANCES MARIE BISHOP and } 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a permit. Pages 1 and : Department of Health Important: If item 27 I any Injury or other tra once. FRANCES M. McCABE/MOTHER 741 NATIONAL HIGHWAY, LAVALE, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CUMBERLAND CREMATORY 04/04/2009 CUMBERLAND, MD 22. Name and Address of Facility
UPCHURCH FUNERAL HOME
202 GREENE STREET, CU 21. Signature of Funeral Service CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (of as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Cumberland. MRS 32. Registrar's State Registrar

Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible.

09-02767	Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are Legible.			
Theodore Maxwell Mills	State of Maryland / Department of Health and Mental	Hygiene	200	19 1250	h
1- For State Registrar	Certificate of Death	Reg. No.	2.00	, , , , , , , , , , , , , , , , , , , ,	
	s Name (First, Middle,Last)	2. Date of Death	Y	3. Time of Death	٦

		Registrar		Certificati	e oi	Deam					eg. No.		
Physicia Iedical Examin	-	1. Decedent's Name (First, Middle, La Theodore M		lls, S	r.					Date of Dea Month April 7, 20	Day 109	Year	3. Time of Death 1055 hrs
		4a. Facility Name (if not institution, g 109 26 Big Pool Road	ive street and number)		41	Big Poc		ocation of	Death	10	1	nty of Death nington	
Funeral Director		214-36-2322		yrs. last birthda 9	ay) Yrs.	If Under	1 Year Days	If Under	24Hrs. 8 Min.		th(MM/DD/Y -1939	Foreig	hplace (State or n untry) MD
th the Maryland 23a or 28a-f show any notified at once,	Usual Residence of Decedent 10a. State								10d. Inside City Limits 1 Yes 2X No				
s after death wi rral", or items	by Funeral	10926 Big Poo 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce 15. Decedent's Education (Specify	12. Was Decedent Eve Armed Forces? 1 Yes 2 X	No	If Ye		Cuban, I No	anic Origir Mexican, F specify:	Puerto Ric		Spec		
036 within 72 hou ene. er than "natt	ompleted	Elementary/Secondary (0-12) 11th grade	College (1-4 or 5+)	dui	ring mo	st of working der	ng Ìife. D	OO NOT u	se retired)	cra	ne m	fg.co.
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, La Ernest Mil	ls					Sal	1y	Clop	-		
MD 2 nd 2 shouls alth and M m 27 is m aumatic e	요.		ills wife		092	26 B:	ig I	Pool	Rd.			, MD	21711 Town, State
Baltimore, permit. Pages I at Department of Hee Important: If ite Imjury or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Speci	fy:		ad ad	er place) Ceme	ete:	ry	Apri 200	1110,	1	Pool	
		21. Signature of Funeral Service Lig	4 - 6	dooth Doors o	Do	onalo	l E	dwin	Tho	ompso	n Fun	eral	Home, Inc
Physician /Medical caminer		failure. List only one cause on	each line. a. Intraoral Shotgun Due to (or as a consequence)	Wound	anter tri	e mode or	ayiiig, s	ucii as cai	Turac or re	зрпаюту ап	est, shook, e	T TICUIT	Between Onset and Death
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, P.O. Box 6 res that the death ce signed by the attend be detached for use	<u>م</u>	Part II. Other significant condition	s contributing to death bu	ut not resulting i	n the u	nderlying c	ause giv	ven in Par	t I.				the cause of death?
Division of Vital Records, tal or Attending Physician: The law requir is after death at Director: After this certificate has been sted in by the funeral director, page 2 should	Completed									24a. Was auto perfo	psy ormed?		utopsy findings available completion of cause of es 2 No
an:	Be	25. Was case referred to medical				26		of Death (0	Check onl	y one)			
Vital Rec hysician: The this certificate	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outp	atient	3 DO	AC	other4	Nursing I	Home 5	Residence	6 🗸 Othe	r: Scene
ion of Vertile or: After the funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig		28b. Tir FOUN 1012 h	D:	njury 28		at Work? es 2 ✔ I	ls:	Bd. Describe ubject she	how injury o ot self	ccurred	
Division Hospital or Attent 24 hours after death Funeral Director:	Sertification:	3 V Suicide 6 Could n determine	ot be 28e. Place of Injury	y - At home, farn e Family Ho		t, factory, c	ffice bu	ilding, etc		or Town.			ural Route Number, City
To the Hospital spithin 24 hours To the Finneral completely filled	Medical C	29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	ician: To the best of my kner:On the basis of examin and manner stated.	nowledge, death ation and/or inv	occuri estigati	ion, in my o	pinion,	death occ	ce, and du	ue to the cau	and place, a	and due to th	ne cause(s)
33	Ž	29b. Signature and title of certifier	hall, mis				D.C.M	number 1.E.			29d. Date April 8,		onth, Day, Year)
		30. Name and address of person who Pamela E. Sputhall, MD		i E	11	1 Penn S	Street,	Baltimo	ore, MD	21201			
Sta Regist	ate ar	31. Date filed (Month, Pay, Year)	32 Registrar's	Signature	No.	I Penn S							

09-02651 James Aubrey N	lartii	Please Type or Print in Black Ind State of Maryland / Depart					ible. 2009	12561	
		- For State Certification - Ce	ficate of Dea			Re	g. No.		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) James Aubrey Martin, Sr.				Date of Death Month April 4, 200	Day Year	3. Time of Death 0249 hrs	
		4a. Facility Name (if not institution, give street and number) 12 Edgewater Avenue		Town, or Locati		7,0111 4, 200	4c. County of Deat	h	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last $222-24-7162$ $1^{\scriptsize{\scriptsize{(X)}}}$ M $2^{\scriptsize{\scriptsize{(F)}}}$ F 71	birthday) If Und Mont		Inder 24Hrs. Durs Min.	8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei 1937		
vith the Maryland s 23a or 28a-f show any e notified at once.	Director	10a. State 10b. County 10c. City, To	Beach	p Code		10	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No ntry?	
th the N 23a or 2		1310 4th Avenue		2960			United Sta		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1/4 Yes, Give Year 1/5 Yes, Give Yes		lent of Hispanic cify Cuban, Mexi 2 X No s <i>pe</i> l	can, Puerto R		14. Race - Amer White, etc. Specify: Wh	ican Indian, Black,	
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's Usua during most of we				16b. Kind of Business	Industry	
036 vithin 7; ene. er than	Completed	12	Oner/Ope				Campgrou	nd	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) John Aubrey Martin			,		aiden Surname)		
212 ould be I Ment:		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres			ude Berryman Rural Route Number, City or Town, State, Zip Code)			
MD od 2 sho alth and m 27 is aumati		Dorothy M. Martin / Spouse	1310 4th					2960	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 XXBurial 2 Cremation 3 Removal from State Nort	nce of Disposition (Na matory or other place h East Me Cemetery	thodist	Apzi.	19	20c. Location - City or North East		
Ball permit Depart Impor injury		21. Signature of Puneral Service Licensee					eral Home	ary1and21901	
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line. Immediate Cause (Final disease a. Inhalation of Smoke and	o not enter the mode					Approximate Interval Between Onset and Death	
Adminier		or condition resulting in death) Due to (or as a consequence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
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O, be exesician a	edical	UNPENDED AMENDED				_			
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death		opic pregnand	ey	23d. Date of deliver Month	y Day Year	
s, P.O. ires that the signed by t	by P	Part II. Other significant conditions contributing to death but not result. Hypertensive Atherosclerotic Cardiovascular Disea		ig cause given i	Part I.		pacco use contribute to		
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the fact death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director.	Completed	Trypertensive Atheroscierotic Gardiovascular Disea				24a. Was a autops perform	n 24b. Were and prior to death?	utopsy findings available completion of cause of	
1 of Vital Recing Physician: The l After this certificate l'uneral director, page	Be Co	25. Was case referred to medical		26.Place of De	ath (Check on		No 1 Y	es Z No	
Vit;	P P	Tes Z No	R/Outpatient 3	DOA Other	T I Italiania		Residence 6 🗸 Othe	r: Scene	
Sion of Attending Photograph. ctor: After to you the funeral	Certification:	1 Natural 5 Pending Apr 4, 2009 Year) 2 Accident Investigation	8b. Time of Injury 0206 hrs		✓ No S	ubject in ho			
Division pital or Attent ours after death teral Director filled in by the	ertifi	3 Suicide 6 Could not be determined Specify Single Famil		y, office building		or Town, St		ural Route Number, City	
Division To the Hospital or Attent within 24 hours after death To the Runeral Director: completely filled in by the	Medical C	23a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at th		d place, and d	ue to the cause	e(s) and manner as sta	ted.	
F 2 4 8	Me	29b. Signature and title of certifier	29	O.C.M.E.	ber		29d. Date signed (Mo	onth, Day, Year)	
10		30. Name and address of person who completed cause of death (Item 2: Russell Alexander MD. Assistant Medical Examin		Street, Balt	imore, MD	21201	<u></u>		
S: Regis	ate trar	31. Date files (Routh Day 2009 232. Registrar's Sinature				OCN	ИΕ		

09-02651

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Year **Physician** 11Vel nolin 2009 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hound Olumbi 9. Birthplace (State or Foreign Country) Rhode Island f Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 07-02-1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 039 07 9371 89 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 28a-f show d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 United States 6336 Cedar Lane #361 by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 No 1940-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1∐Yes 2∑No Specify White 3 Widowed 4 Divorced 1952 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If them 27 Is marked other the any injury or other traumatic event, the ORGS. Shipping Businessman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Matthews Arthur Morin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gisele Morin-Connolly/Daughter 12113 Blue Paper Trail Columbia, MD 21044 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-8-2009 Ardent Crematory Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Collin 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alheroscioni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pagr 41 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number $(s) \infty$

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 April **Physician** Joseph Frank Main, Jr. 12, 2:45 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 20306 Cedarhurst Way Germantown Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 2, 1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 213-24-7613 1**X** M 2 □ F 81 Mary Tand Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the destion Examinate must be motified at Director Maryland Montgomery Germantown 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20306 Cedarhurst Way 20876 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces r 1X Yes 2 No If Yes, Give 1944 - 1947 Year or Date 1944 - 1947 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify: ģ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill the and Mental H Be Joseph Frank Main, Sr. Evelyn V. Ridenour ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 18100 Windsor Hill Drive, Onley, MD 20832 Mrs. Verena L. Rose, daughter Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Apr. 17, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of the erall Service Limitsee Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stroke disease or condition resulting in death) 1 hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar that initiated event resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending properties for use as use as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 ☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 st 24a. Was an Hyperlipemia autopsy performed Previous Stroke 1 □Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes ZNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760, P.O. I Division of Vital Records, Hospital or Attending Physician: After this funeral

1X Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

29a. Certifier

29b. Signature and title of certifier

4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

and manner stated

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D 31839

29d. Date signed (Month, Day, Year) April 13, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher . Dunford M.D., 615 W. Montgomery Ave., Rockville, MD 20850 31. Date filed (Month strar's Signature

State Registrar

npletely within 24

To the F

complete Medical

DHMH 17 Rev 1/2001 12 DIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

		1	For State Registrar	State of Maryland	•	tificate of E			Reg. No. 🥎	000	12561	
			Decedent's Name (First, Middle, Las	t)				2. Date of De Month	ath Day	Year	3. Time of Death	
	Physicia		Lonnie	McNair Sr				April			9:30A M	
· .	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. Cour	nty of Death		
-/-	Funeral		Hartland of Ad 5. Social Security Number 6. S		st birthday)	Ade1	If Under 24 Hrs.	8. Date of Bir (Month, Da			Beorges place (State or Foreign party)	
	Director		250-48-9798 1 Usual Residence of Decedent	⊠ M 2□ F 76	Yrs.	Months Days	Hours Min.	Aug. 16	1932	SC		
	/land		10a. State 10b. County	10c. City,	Town or Loc	cation				1	IOd. Inside City Limits	
	Mar a-f st	içi	MD PG	Ca	pitol	Height	S				1 X Yes 2 ☐ No	
	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen		•	
	23a	ᇛ	606 Drum Avenu			2074		" V 1	Unite			
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puerto	pecity Yes of No o Rican, etc.))- 14. F	Race - Amerio Black, White,		
36	rs afte	Ŕ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∑X No If Yes, Give Year or Dates:		I∐Yes 2⊠No	Specify:		Spe	cify: Bla	ack	
2-00	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is five from traumatic event, it is five from the traumatic event, it is five from the traumatic event, it is five from the traumatic event.	Completed	15. Decedent's Ec	lucation de completed)	16a. Deced	dent's Usual Occupa kind of work done of OO NOT use retired	ation during most of worl	king	16b. Kind of	Business/In	ndustry	
121	within 7 iene. than "r	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Driver			Self-Employed			
22	filed w Hygie other t		17. Father's Name (First, Middle, Last)		Car	DIIVCI	18. Mother's Nam	ne (First, Middle			Loyeu	
an	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It e It.	To Be	Jesse McNair				Mary Le	ee Mill	ler			
Ĭ	should and Mer s marke umatic	Ĕ	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a		ıral Route Numb	oer, City or To	wn, State, Zij	p Code)	
Σ	and 2: ealth a n 27 is ner trau		Junna McNair/w	rife	606 Capi	Drum Av Ltol Hei	enue ahts. N	ID 2074				
Je,	of He of He item		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location	on - City or To	own, State	
<u>E</u>	Page nent ant: If ury o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	removal from State Ft.	Line	coln Cem	etery 4	1/17/09	Bre	entwoo		
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licer	isee) 22	2. Name and Addres	ss of Facility Ho ver Hill	odges &	& Edwa Suitl	ards I	F.H. Md.20746	
			23a, Part 1. Enter the disease, or com	plications that caused the death							Approximate Interval Between	
	Physician		Interval Detreeth Onset and Death Onset and De									
	/Medical		resulting in death)	Due to (or as a consequ								
	Examiner	L	Sequentially list conditions,	b						-	1.00	
	led Isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ierice ot):				-			
•	ficate be executed g physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):							
68760,	e be e		•	d								
687	± 50 88	edical										
Box	eath certifi aftending for use as	J/N	IF FEMALE: 23b. Was decedent pregnant		c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					Date of delivered Month	very Day Year	
O. B	The law requires that the death certate has been signed by the attendinage 2 should be detached for use	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (specify)				WOTH	buy .ou	
σ.	that the		Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?	
of Vital Records,	w requires to been signer should be a	d by						1 🗆	Yes 2⊟1Ñ	o 3 □ Pro	obably 4 Unknown	
COL	w req	Completed						24a. Wa		4b. Were aut	topsy findings available completion of cause of	
Be	The law te has age 2 a	m o							opsy formed? 2 40	→ death?		
ital		O.	25. Was case referred to medical				26. Place of De					
\S	S S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 □ DOA Oth	er: 4 Nursing I	Home 5 ☐ Res	sidence 6	Other (Spec	cify)	
0 U	ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	k?	28d. Describe	how injury oc	curred		
sio	Attendia death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		ome faces of		lYes 2□No	28f Location	(Street and N	umber or Ru	ral Route Number,	
Division	or / or / or / or / or /	Certification:	4 ☐ Homicide determined		y)	reet, lactory, office		City or To	own, State)		,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the ti nvestigation, in my	ime, date and place opinion, death occ	e, and due to the	ne cause(s) an e, date and pla	d manner as ace, and due	s stated. to the cause(s)	
	To the within 3 То the сотре	Med	29b. Signature and title of certifier			29c. Licens	se number			igned (Month		
	F>F0)	TI, MD		_ 1000	06010	0	04	-14	-09	
			30. Name and address of person who	completed cause of death (Iten	n 23a) (Type	Print)	Hanin A	1C/	74 MF	2		
	St	ate	31. Date filed (Month, Day, Year)	32. Régistrar's Signa	ature	B 0	/ - /			,		
	Regist		APR 20	2009 Sinser	1. 14	Darker						

De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanting must be notified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

For State Registrar	State of Wi	Ce	ertificate of		Reg	0001	9 12565
1. Decedent's Name (First, Middle,	,				2. Date of Death Month	Day Year	3. Time of Death
Gladys Daphne O	SBORNE				April	08 200	
4a. Facility Name (If not institution, g				r Location of Death		4c. County of Dea	
Washington Coun			Hagers // If Under 1 Year		9 Date of Birth		ngton
225-03-3167	Sex 7. Ag	e (In yrs. last birthday 94 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	1915 V	thplace (State or Foreign ountry) 'irginia
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Maryland Wash	ington	н	agerstown				1 XYes 2 No
10e. Street and Number	Ingcon	11	10f. Zip Code		10g.	Citizen of What Co	ountry?
1005 Washington	Avenue			21740		USA	
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 1 1 Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 ☑ No		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify:	
15. Decedent's (Specify only highest)	Education grade completed)	16a. Dec	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of work	ing 16l	o. Kind of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or)+)	. DO NOT use retire borer	d)		factory	,
10 17. Father's Name (First, Middle, La	0	La		18. Mother's Nam	e (First, Middle, Mai		
James Alfred Sy				Tamer		,	
19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	iling Address (Stree	and Number or Ru	ral Route Number, C	ity or Town, State,	Zip Code)
Paul Russell Sy	nan – broth	ner Box	607, Poc	ahontas,	Virginia :	24635	
20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			position (Name of ematory or other plane) Mem. Par			Location - City or	3
21. Signature of Tuneral Service Lic			22. Name and Addr		MINNICH F		
SEATH	MAIN	mil	415 E.Wil		, Hagerst		
23a. Part 1. Enter the disease, or co	emplications that cause	the death. Do not					Approximate Interval Between
shock, or heart failure. List or Immediate Cause (Final	ily one cause on each il	ne.	C /				Onset and Death
disease or condition resulting in death)	a. Due to (or as	a consequence of):					2
	الما الما الما الما الما الما الما الما	Lilia	Pheno	ش			1
Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					(- 31
Sequentially list conditions, if any, leading to immediate eause. Enter Uniderlying Cause (Disease or injury that initiated events C.							
resulting in death) Last	Due to (or as	a consequence of):	****				
	d						
IE EENALE.	-					1	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	B ☐ Ectopic pregnan D ☐ Other (specify)	су		23d. Date of de Month	elivery Day Year
Part II. Other significant condition	s contributing to death to		underlying cause gi				o the cause of death?
carrie Vance							
Ingulia ken			Truct i		24a. Was an autopsy performe	d? death?	
25. Was case referred to medical		,,,,,	, , ,		1 ☐ Yes 2 E th (Check only one)	⊒IVO 1 LIYe	s 2□No
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpati	ient 3 DOA Ot		ome 5 ☐ Residence	e 6 □Other (So	ecify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time	of 28c. Inju	ry at rk?	28d. Describe how		
2 Accident investiga 3 Suicide 6 Could no		A4 harra - 5-11]Yes 2 □No	Of Londing (C:	t and Number c - F	Rural Route Number,
4 ☐ Homicide determin	28e. Place of In	iury - At home, farm, s c. <i>(Specify)</i>	street, factory, office		City or Town, S		nurai Houte Number,
29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis and manner s	of examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the cau rred at the time, date	se(s) and manner a and place, and du	as stated. ne to the cause(s)
29b. Signature and title of certifier				s <i>e</i> number		. Date signed (Mor	
- 12LE 1			DI	8019	A	P212 9	2009
30. Name and address of person w	no completed cause of	death (Item 23a) (Type	e, Print)				2 12:
·	TUL MO	3200	mile &	7 476	ERITOL	in mi	21740
31. Date filed (Month, Day, Year) APR 0 9		rar's Signature	base				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nor 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Rudolph William Olup April 6, 2009 9:20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvery Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F Months 578-07-8400 May 4, 1918 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Charles Benedict 1 ☐ Yes 2 No 10e. Street and Number 18623 Bells Hotel Place 10g. Citizen of What Country? 10f. Zip Code 20612 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Xes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No White 1□ Yes 2□ No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Burner Service Manager Besche Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Olup Martha Helms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Olup/Son 19015 Creeks End Place, Benedict, MD 20612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 14, 1 XBurjal 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Maryland Veterans Cem. 2009 Dopation Cheltenham, Maryland 21. Signature of Fyneral Solvice Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio vasular disease Atheroscienotic Due to (or as a consequence of) Sequentially list conditions, in any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Failure Renal 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 2 No 1□ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760. attending ph To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Physician/Medical

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Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Madestal

Physician

/Medical

Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pseudomembranous colitis 25. Was case referred to medical examiner? 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50653 4-6-2009 C

GYAN . C. FURANT

State Registrar

31. Date filed (Month, Day, Year) APR 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surventon Road Deale inD

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea **Physician** Phillip Allen Owen 9:45 PM 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBUR WICOMICO castal Hospice HT the If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 329-44-5156 1 X M 2 □ F 58 Director 02/13/1951 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating that be mailled at Director 1 ☐ Yes 2 X No Wicomico Salisbury Maryland 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 27501 Trotters Run 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 M Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or i any Injury or other traumatic event, It is Medical Examination. ltimore, Maryland 21215-0036 1 ☐Yes 2 🛮 No Specify: white Specify: <u>۾</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Director of Human resources Mt. Aire Farms 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel P. Owen Mary Lou Alfrey ပ 19a. Informant's Name/Relationship (Type. Print)
Nancy K. Owen/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27501 Trotters Run, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Oaks Cemetery 4/11/09 4 □ Donation 5 □ Other (Specify) Houston, TX ignature of Funeral Service Licensee ² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 Box 68760 physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a P.0. 9 I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t autopsy performed? 1 □Yes 2 No certificate of Vital director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: Injury at Work? Division Natural 5 Pending n 24 hours after death.

• Funeral Director: A

pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 1/2001

State

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lle

trar's Signature

401

3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 11:40 PM Helen J. Purnell 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Atlantic General Hospital Berlin Worcester (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 3(1/19/19/23ear) 9. Birthplace (State or Foreign Country) D \(\bar{\chi} \) 6. Sex Days Hours Min. 1 D M 2 D F PA 199-14-3883 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Completed by Funeral Director MD Worcester Ocean Pines 10e. Street and Number 10g. Citizen of What Country? 14 Newport Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify: white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Jones Helen K. Keane ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6620 Belle Chase Ct., Gaithersburg, MD 20882 Gary G. Harman / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garden of the Pines 4/11/2009 4 □ Donation 5 □ Other (Specify) Ocean Pines, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signatur of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheelmonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 □No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ★ Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

/Medical Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Division of Vital funeral director, spital or Attendii ours after death. neral Director: A To the Hospital or within 24 hours at Purnell, within 24 hours a

Physician/Medical Examine

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Completed

Be

Certification: To

Medical

29a. Certifier

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examirer must be notified at

Pages 1 and 2 should be filed within 72 hours after death with then of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or:

ry or other traumatic event, the Medical Experiment near

permit. Pages 1
Department of H
Important: If ite
any injury or ot

Physician

Baltimore, Maryland 21215-0036

BA20

State Registrar

29c. License number D0064120

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGH 9733 Health Way drive Berlin Zeeshah

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4 2009 2:06 a^{M} Mary Jane Pistorio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Vantage House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 💆 F Director 12/5/1917 NJ 221-09-9556 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 21044 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Exemptor Installat 5400 Vantage Point Rd. #1016 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ၨNo Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giovanna D'Angelo Francesco Vassallo ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5221 Lynngate Rd., Columbia, MD 21044 Don Pistorio / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-4-2009 5 Other (Specify) Ardent Cremation Hanover, MD Funeral ce Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Sign vu M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Esophageal Cancer **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter throughing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ Mo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 ✓ No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 □Yes 2 □No I Director: A death 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(6) PD State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10100 Charker Orice Colleges, MD

MP

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

0-53636

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ı	Physici		1. Decedent's Name (First, Middle, Last) William Lewis Russ			-		2. Date of Death Month March 3	B1, 2009	3. Time of Death 2101 M
	/Medic Examin		4a. Facility Name (If not institution, give street and numb	III CII	4c. County of Death					
1			Anne Arundel Medical Cer		Anne An	rundel				
	Funeral Director		579–32–1807 ^{™ 2□ F}	Age (In yrs. las 81	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1		place (State or Foreign intry)
	land bw f		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
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	or 282	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	23a		12711 Springfield Court			2075	54		USA	
036 urs after dea	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the "Redical Eventher "sust be neithed at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decede Armed Force 1 ☑ Yes 2 □ If Yes, Give Year or Date	s? ⊒No		/as Decedent of H Yes, specify Cuba □Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: Wh	
215-0036	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occup	eation during most of work d)	ing	6b. Kind of Business/li	ndustry
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õ	8 × 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	le i		ition (Name of atory or other place		10	c. Location - City or T	
Baltimore,	permit. Pag Department Important; any Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	wary		Veterans Name and Addre			heltenham, Home Calv	
ñ	any per		Gary J. Coff				nern Mary			
1	Physician		23a. Part a Enter the disease, or complications that caushock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	ed the death.	Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or	as con eque	nce of):	•	/			
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0 0	ng Phys fter this neral dir	n: To	27. Mannar of Death 28a. Date of I	njury 20 Day, Year)	8b. Time of Injury	28c. Injury Work	4 LI Nursing Ho	me 5 ☐ Residene 28d. Describe how	ce 6 ☐ Other (Speci injury occurred	fy)
SION	tendil eath. or; A the fu	catic	2 Accident investigation			M 1 🗆	Yes 2 □No			
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	4 Homicide determined 286. Place of building,	City or Town, S	on (Street and Number or Rural Route Number, Town, State)					
	he Hosp in 24 hor he Fune pletely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best and manner	of examinatio	edge, death on and/or inv	occurred at the tirestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	use(s) and manner as e and place, and due t	stated. o the cause(s)
)	Tot Tot	2	29b. Signature and title of certifier Whose purple of the control			29c. License	6 37 6	290	1. Date signed (Month,	Day, Year)
RI	8		30. Name and address of person who completed cause of	death (Item 2	3a) (Type, P	int) no	anh.	Λ.	Del .	1D 21401
	Stat			strar' Signatur	re /	uce V	Memori	1 1 Auna	yours 14	שויג עו
	Registra	ll'	APR 0 3 2009▶	Chrown	1 11.	Backet	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ď William Augustus April 2009 /Medical Robb 1:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert

9. Birthplace (State or Foreign Country) Calvert Memorial Hospital Prince Frederick 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F **Funeral** Months Days Hours Min. Director 212-54-5512 58 Aug.26 1950 Indiana Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7965 Kimberly Place USA 20640 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 379 1 ☐ Yes 2 ➡ No Specify Specify:White ģ 3 ☐ Widowed 4 ☑ Divorced "natural", Completed the Medica 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene.
77 is marked other than (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce Albert Robb Martha Strubel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William M. Robb/Son Health tem 27 3505 Floral Park Rd. Brandywine, MD. 20613 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or oth X☐ Burial 2 ☐ Cremation 3 ☐Removal from State Mem. Grdns 4/6/09 Waldorf, MD 4 Donation 5 Other (Specify) Trinity 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signatur uneral Service License M00982 2294 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BICATERAL ZUNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or se a consequence of) Examiner use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) been signed by the sahould be detached 1 Tyes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? this certificate 2 **4**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 certificate be P.O. I

72 hours after

Baltimore, Maryland 21215-0036

Division or Vital Records, To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Dr. Mukesh Mathur 31. Date filed (Month, State

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Prince Frederick, MD. 20678
32. Registrar's Signature

29c. License number

APR 0 6 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 2. Date of Death Month Day March 30, 2009 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2:25 Bessie Roy 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)

 \mathbf{P}^{M}

for State Registrar

Physician

/Medical

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	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🖾 F	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hours N	Vlin. (Month, Day	h v, Year)	Birthplace (State or F Country)	oreign	
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Dallimor	보본분들 .		21. Signature of Funeral Service		рауч				Beall Fune				
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buts after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ledical (29a. Certifier 1 ☐ Certifyii (Check only one)	ng Physician: To the be Examiner: On the bas and manner	is of examina	wledge, dea tion and/or i	th occurred at the nvestigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as stated. and due to the cause(s)		
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09-02833 Patrick Lee Riale Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atrick Lee Riale		- For State	ate of Maryla	and / Depa	rtment o		Mental H		g. No.	2009	1257
Physiciar ledical Examin	/ 1	egistrar I. Decedent's Name (First, Middl Pa	_{e,Last)} trick Lee	Riale				2. Date of Death Month April 9, 200	Dav Ye	3. Time 1126	of Death 6 hrs
	4	a. Facility Name (if not institution 98 Starboard Court	n, give street and nu	imber)		4b. City, Town, or Lo Perryville			4c. County Cecil		
Funeral Director	5	5. Social Security Number 218-76-1784	6. Sex	7. Age (In yrs. I	ast birthday) Yrs	If Under 1 Year Months Days s.	If Under 24H Hours Mi	_		Y) 9. Birthplace (5 Foreign Mar Country)	state or -yland
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by MD 21215-0036 and 2 should be filed within 72 hours a realth and Mental Hygiene, tem 27 is marked other than "natura traumatic event, the Medical Examiration of the Medical Examira	mpleted	Elementary/Secondary (0-12) Twelve Years		1-4 or 5+)		istant Ma	nager	me (First, Middle, N		astle, De	elaware
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	e l	17. Father's Name (First, Middle Star 19a. Informant's Name/Relations	nley Riale	e, Jr.	19b. Mailir	ng Address (Street		Peggy	Wyatt		de)
두 말씀 든 때		Brandy Riale 20a. Method of Disposition	(wife)			East Ridl esition (Name of cementher place)		., Ridley		PA 1907 n - City or Town, S	
Baltimore, vermit. Pages I ar Department of Hes Important: If iten injury or other tr		1 X Burial 2 Crematio 4 Donation 5 Other S 21. Ingrature of Funeral Service	pecify:		sebank	Cemetery Name and Address ee A. Pat			1	Sun, Mar	
Physician	+	23a. Part I. Enter the disease, of failure. List only one cause	r complications that a on each line.	caused the death	n. Do not enter	Perr the mode of dying, s	yville, such as cardia	Marylar c or respiratory arr	d 21 est, shock, or r	903-0/66 neart Appro	oximate Interval een Onset and
Medical caminer		Immediate Cause (Final disease or condition resulting in death)		xvphene a consequence		cation					Death
d d	盲	Sequentially list conditions, if any, leading to immediate ceues. Enter Underlying Cauco (Disease or injury that initiated events resulting in death) Last	c	a consequence							
e execut cian and rial - tra	dical	XUNPENDED	d AMENDED	23a,27	,28a-f,	perME, g8	91 5/1	4/09 TT			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate but the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ut	the 1 Live	, outcome of pre birth gnant at time of c nown	2 F	Fetal death 3 Dther (Specify)	Ectopic pres	gnancy	23d. Date Month	of delivery Day	Year
b, P.O. Baires that the de signed by the	- 1	Part II. Other significant cond	itions contributing	to death but not	resulting in the	e underlying cause g	iven in Part I.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ntribute to the cause	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed by				_					b. Were autopsy fii prior to completi death? 1 Yes	
1 of Vital Recing Physiciau: The Affer this certificate funeral director, page	Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	al Hospital: 1	Inpatient 2	ER/Outpatie		of Death (Che Other Nu		Residence 6	6 🗸 Other: Scene	
on of \ ending Ph; ath. r: After the funeral	tion: To	27. Manner of Death 1 Natural 5 Per	nding F.d	e of Injury th, Day,Year)	28b. Time o		ry at Work? Yes 2 X No	28d. Describe unk	how injury occ	curred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Co	uld not be ermined (Specific	ace of Injury - At y) at ho	me	reet, factory, office b		Perryv	ille, M	mber or Rural Rou Starboar	te Number, City d Ct
To the Hospital within 24 hours To the Funeral completely filled	edical	one) 2 Medical Ex	Physician: To the basis aminer:On the basis and manner	s of examination	edge, death occ and/or investig	gation, in my opinion	, death occurre	and due to the cau ed at the time, date	and place, an	d due to the cause	
	Ž	29b. Signature and title of certi	L mo			29c. Licens			April 10,	igned (Month, Daj	y, rear)
Ē.		30. Name and address of person Donna M. Vincenti, N		use of death (Ite Medical Exa		11 Penn Street	, Baltimore	, MD 21201			
Sta	ate	31. Date filed (Month, Day, Yea	32.	Registrar's Signa	ature	,					

ORIGINAL

Phys /Mo Exa

Fune Direc

y: Mo	sic ed m	cian lical	
thin 24 hours after death.	the Funeral Director: After this certificate has been signed by the attending physician and	empletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

	1 = For State Registrar	State of Maryland		tificate of			Reg. No. 2	009	1257
an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
al		nell Staffo	rd	th Oite Town o	Leastion of Doo	March		009 nty of Death	9:04 A
er	4a. Facility Name (If not institution, give	,		4b. City, Town, or					
-	Calvert Memorial I 5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	Frederic	S. 8. Date of Birt	h Ca	1vert 9. Birthp	place (State or Foreig
	218-24-3697	М 2√Г 80	Yrs.	Months Days	Hours Min	8. Date of Birt Month, Da Nov 14	1928	Mary	yland
	10a. State 10b. County		Town or Loc					1	10d. Inside City Limit
ç	Maryland Calvert	Pri	nce Fr	ederick					1 ∐ Yes 2 📆 N
al Director	455 Hallowing Poir	nt Road		10f. Zip Code	20678		10g. Citizen o Unite	of What Cour d Stat	
Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. V	Vas Decedent of H	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. F	ace - Americ	
by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 □ No If Yes, Give Year or Dates:		□Yes 2 No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		cify: whit	
etec	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Deced	ent's Usual Occup kind of work done of OO NOT use retired	ation during most of wo	orking I	16b. Kind of	Business/In	dustry
Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	homem		d) -	_	own	home	
To Be C	17. Father's Name (First, Middle, Last) Guy Walter Wilbur	rn				ame (First, Middle, e Viola O		ame)	
	19a. Informant's Name/Relationship (Ty Jennifer Mattera- o	'	Į.			Rural Route Numbe			
	20a. Method of Disposition			sition (Name of eatory or other place		Date	20c. Locatio		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Asb	ury Ce	metery A	pril 3,	2009	Barsto	w Mary	land
	21. Signature of Funeral Service License	96	22	Name and Addre	ss of Facility Ra	ausch Fun Rd. Port	eral H	ome	20676
	27000		-					IC MU	
	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. ACUTF M	YOCA	RUIM	INFA	rec (12n			MINUTE
		Due to (or as a consequence)	ence on.						YEAR
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque		CARDIOI	730000	200011		-	/ (M/C)
Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events		,					- 4	
Xal	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
cal		d.							
Jedical									
	230. was decedent pregnant	23c. If yes, outcome of pregnan		l Estania prognana			23d.	Date of deliv	very
Completed by Physician/I	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of de] Ectopic pregnand] Other <i>(specify)</i> _	у			Month	Day Year
hys	9 🗆 Unknown	9 Unknown							
ΣP	Part II. Other significant conditions con	ntributing to death but not resul	Iting in the un	derlying cause giv	en in Part I.	,		ontribute to t	the cause of death?
g	HYPPRTFUSION					_ 1 _1	res 2□No	3 □ Pro	bably 4 Unknov
olet						24a. Was		b. Were auto	opsy findings availab
mo						- autop perfo 1 □ Yes	rmed? 2 🔄 No	death?	•
BeC	25. Was case referred to medical		-		26. Place of De	eath (Check only o		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2 2 1 1 1 2
	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth	ori	Home 5 ☐ Resid		Other (Speci	ify)
	27. Manner Death		28b. Time of Injury	28c. Injui Wor		28d. Describe I			,
atio	1 4 Tatura! 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, rear)	пдагу		Yes 2 □ No				
ij	3 Suicide 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (3	Street and Nu	mber or Rur	ral Route Number,
Sert	4 Homicide determined	building, etc. (Specify)	/			City or Tox	ni, state)		
Medical Certification: To	29a. Certifier Certifying Physics (Check only one)	rsician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tivestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and place	manner as e, and due t	stated. to the cause(s)
Me	29b. Signature and title of certifier	1 0		29c. Licens	se number		29d. Date sig	ned (Month,	, Day, Year)
	I Clock is my	angling			16358		MAR	ch	31,2009
	30. Name and address of person who co	. WEIGHT	17)		FFRE	DERICK	- m	0-20	1678
te	31. Date filed (Month, Day, Year)	32. Registra's Signatu	ure						
ır	APK 03	3 2009 Deneus	1 1.	parket	' 				
01									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	iviai yiai i		rtificate of	Death		g. No. 200	9 12575
	Physici	an	1. Decedent's Name (First, M	fiddle, Last)					2. Date of Death Month		3. Time of Death
	/Medic		Helen Lucretia Sr							h 23, 2009 Ye	02:22 A M
	Examir	er	4a. Facility Name (If not instit		nber)		4b. City, Town, o	r Location of Death		4c. County of D Allegany	eath
			10954 Green Row 5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Year	Zihlman If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director		218-16-3818 Usual Residence of Deceden	1 □ M 2 💆 F	84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, December 2		Country) Maryland
	/land		10a. State 10b. Con		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mar)	향	Maryland A	Allegany	Fro	stburg					1 □Yes 2 XiNo
	or 28)ire	40 01 1 121 1	954 Green Row I			10f. Zip Code		10	g. Citizen of What	Country?
	23a c	ra		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			21532-		1	U.S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evarinar roust be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2□ 3 ☑ Widowed 4 □ Divo	Armed For Married 1 ☐ Yes If Yes Giv	2 No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 14No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, W Specify:	merican Indian, hite, etc. Vhite
0-0	2 hot	ted	15. Dece	edent's Education		16a. Dece	dent's Usual Occup	pation		6b. Kind of Busine	
216	thin 7 le.	nple.	Elementary/Secondary (0-1		-4or 5+)			during most of work d)	1		
	ed wi		10	0		home	maker			homemaker	
and	be fill	Be	17. Father's Name (First, Mid						e (First, Middle, M Frankenberr		
Ž	should and Men s marke umatic	ပ္	Albert Charles R			10h Maili	na Addrass (Street	and Number or Ru			a Zin Coda)
Maryland	id 2 s Ith an 27 Is		Karen Lancaster		PT		Green Row F		stburg	Marylan	· · · · · · · · · · · · · · · · · · ·
	f Health trem 27 l		20a. Method of Disposition	vaugin			esition (Name of matory or other place			Oc. Location - City	
Ë	Pages nent o nt: If		1 ☐ Burial 2 🛣 Cremat 4 ☐ Donation 5 ☐ Othe	ion 3 □Removal from S er <i>(Specify)</i>	state		and Crematory	i	rch 24, 2009	Cumberland	Maryland
Baltimore,	permit. Pages 1 Department of I Important: If Ite any Injury or of once.		21. Signature of Funeral Ser		e		2. Name and Addre	ess of Facility	Don't Ass. 1	7 1.6	D 01520
			23a. Parl. Enter the diseas	e or complications that or	LAT	Do not en		ral Home, 57			
	Physician /Medical	Q 11	hock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only one cause on ea	exoscle	ratic		svascula			Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequ	ence of):					
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	rificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to the conditions of the c	1							
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P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2/☐ No 9 ☐ Unknown	¹ 1 ☐ Live b	come of pregnal pirth 2 ☐ Fetal lant at time of de pwn	death 3[☐ Ectopic pregnand ☐ Other (s <i>pecify)</i> _	су		23d. Date of Month	delivery Day Year
т. П	s that med b	by Pł	Part II. Other significant cor	nditions contributing to de	ath but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ğ	w require s been sig should b	pe p							1 ☐ Ye	s 2 □ No 3 □	Probably 4 Unknown
Records,	ding Physician: The law re h. After this certificate has be funeral director, page 2 sho	Completed				<u> </u>		.,	24a. Was an autopsy perform	/ prior ned/2 deat	
Vital	stan: ertifica etor, p	Be C	25. Was case referred to me	dical					th (Check only one		7
of V	hysic this co		examiner? relea	sea Hospital: 1□	npatient 2 🗆 I			4 LI Nursing H	ome 5 Reside	nce 6 Other (5	Specify)
ion	ending Prath.	ation:	Z [] Noolden	vestigation	of Injury h, <i>Day</i> , Yea <i>r)</i>	28b. Time o Injury	Wor	ryat rk?]Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	al or Attus after de safter de la Directo	Certification: To		ould not be etermined 28e. Place buildir	of Injury - At ho ng, etc. <i>(Specify</i>	me, farm, str	reet, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (tifying Physician: To the lical Examiner: On the ba and mann	asis of examinat						
	To th To th	Me	29b. Signature and title of ce	rtifier			29c. Licens		1	d. Date signed (M	
	may kn		wow	rockshin	MD		POC	55325		Murch 2	3,2009
0.4·	Co Barbara		30. Name and address of per	rson who completed caus		23a) (Type,	Print)			land w	1021502
Ĭ	310		31. Date filed (Month, Day,)	1 1 1 0	egistrar's Signat	ure	arked			*	<u></u>
	Registr	air	THIT	₩ I ZUUJ ///	www !	J. 100	and the				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1:40 P M March 27. 2009 Siblev Dorothy May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 12411 Limestone Road, SE Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/01/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 88 Maryland 215-20-6519 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Northeal Francisms out by the children 1 ☐ Yes 2 No Director MD Allegany Cumberland the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21502 USA 12411 Limestone Road, SE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ites 1 Never Married 2 Married 1 □Yes 2√No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐Yes 2√∑No Specify: 2 White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmiston Bell Ensey Laura Hager Harry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Route 3 Box 452, Ridgeley, WV Clarence K. Sibley / Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any Injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory | 03/30/2009 Cumberland, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Alams Family Funeral Home, P.A. 21. Signatura of Funeral Service Lie 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jochemen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner atheroaco Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examlner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 Ne 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 □Yes 2 □ No 24 hours after death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MN D17565 March 27, 2009

2

State 31. Date fi

J. Bollino, M.D., 922 National Highway, LaVale, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony

			For State		State of Ma	arylan		oartmer e <i>rtifica</i> :						200		1.05	
			Registrar	- /Fine Added n 1 o	ot)			ertilica	e or i	Jeani		2. Date of Dea	eg. No.	200	3 7	Time of Dea	Dath /
	Physicia	an	1. Decedent's Name		Harvey	,		Shaw,	In			Month	Day		.	1:00	
and the same	/Medic		Heni		re street and number)					Location		Merch		County of De		, w	
	Examin	er	-	_	Rehab & E:		Care		Cumbe	erlar	ıd				egan	•	
	Funeral		5. Social Security N	lumber 6. 5	Sex 7. Ag	e (In yrs.	last birthda	y) If Unde	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day 12/20/	Year)	9. B	ountry)	State or Fo	oreign
- 6	Director		217-10-7	300	MM 2□F	39	Yrs.					12/20/	1919	Ma Ma	ryla	nd ————	
	and		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or	Location			······				10d. ln	side City L	Limits
	Maryl -f sho	ţoţ	MD	Alleg	gany			Cumbe	rlan	d					1	□Yes 2[χNο
	n the	Director	10e. Street and Nu	mber				10f. Zi	p Code				10g. Cit	izen of What C			
	hours after death with the Maryland ural", or items 23a or 28a-f show it Exzeritor must be rediffed at	la [17015	Buckley F	Road, SE	_			2	1502 ———				USA			
	tems tems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?			B. Was Dece If Yes, spe	edent of H ecify Cuba	ispanic O an, Mexica	rigin? (Spe in, Puerto F	cify Yes or No- Rican, etc.)		 Race - An Black, Wh 		dian,	
36	safte	by F	1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married	1 MYes 2 ☐ If Yes, Give Year or Dates:	No 194	14-	1 □Yes	2 ∏ No	Specify	<i>:</i>			Specify:	Whi	te	
215-0036	hour			15. Decedent's E		194	16a. Dec	cedent's Usi	ual Occup	ation			16b. Ki	ind of Busines	s/Industry	,	
215	e. B. Bin "ing	plet	(Spec	cify only highest gro	ade completed) College (1-4or !	5+)	(Gir	ve kind of w . DO NOT u	ork done d use retired	during mo d)	st of workin	ng					
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T P	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination in the rectified at once.	Be	17. Father's Name Henry	(First, Middle, Last	Harvey		Sha	aw, Sr			er's Name	(First, Middle,	Maiden	_	erts	on	
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Shaw Baltimore,	Pages lent o nt: If i			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State					i	v 037.	31/2009	1	Flintst	ono	MD	
alti	permit. Departminite importal importal any injuite once.	Ιij	21. Signature of Fe		•	1110	160	22. Name a	ind Addre	ss of Faci	ity Adai	ms Fami	ly :	Funeral	Hom	e, P.	. A .
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	Physician	r i	Immediate Cause	on	a. Meta	ista	HC	m	osta	ite	Ca	noon				re ye	
	/Medical Examiner		resulting in death)	•	Due to (or as	a conseq	quence of):										
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ó	exec		resulting in death)	Last	Due to (or as	a conseq	uence of):										
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o.	the de	ysic	1 ☐ Yes 2 9 ☐ Unknowr		9 ☐ Unknown	at time or	ueam	5 LJ Other (specify)						_		
σ.	that the post of t		Part II. Other signi	ificant conditions	contributing to death b	out not res	sulting in the	underlying	cause giv	en in Part	l.	23e. Did to	bacco	use contribute	to the ca	use of dea	ath?
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o S	aw rei	Completed										24a. Was		24b. Were	autopsy f	indings ava	ailable
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u C	Jing F After funera	ion:	27. Mapner of Dea	ith 5 ∏Pending investigatio	28a. Date of Inj (Month, Da	ay, Year)	28b. Time Injur	y M	28c. inju Wor	ryaτ 'k?]Yes 2.[28d. Describe h	iow inju	ry occurred			
isi	Attending r death. sctor: After by the funer	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not I	oe See Place of In	jury - At h	jome, farm,			103 = 1		28f. Location (S	Street a	nd Number or	Rural Roi	ute Numbe	er,
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directorial.		29a. Certifier (Check only	1 Certifying P	hysician: To the besi	t of my kn	owledge, de	eath occurre	ed at the t	ime, date	and place, eath occurr	and due to the	cause(:	s) and manner	as stated	cause(s)	
	the H hin 24 the Fl	Medical	one)		and manner s	tated.						,		ate signed (Mo			
	4.4	2	29b. Signature and	a title of certifier	Ella:	MI	0	2	ou. Licens	se numbei	36			wich 2			4
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	Sta	ate	31. Date filed (Mo	nth Day Year)	32. Regist	trar's Sign	ature	KAUS	KI 17C	<u> </u>	CUIT	WI KUK	لندح	10 01	~ <u>~</u>	L	
	Regist		MAH	7 J V 2009	Chrown	1.	Dar	Land .									

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 U U 9 2578 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5^{Day} Month 4 2009 **Physician** 3:59 A M George Edward Shockley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worcester Snow Hill 308 S. Church St. If Under 1 Year | If Under 24 Hrs. 3. Date of Birth 1/3/1942 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 X M 2 □ F MD 215-38-0700 67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Matter Examine I rest be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 TXNo Funeral Director MD Worcester Snow Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21863 308 S. Church St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Master Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel White Base Shockley ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 308 S. Church St., Snow Hill, MD 21863 Iva Frances Shockley / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/6/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. Approximate Interval Between Onset and Death Immediate Cause (Find **Physician** namic years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence or, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has t page 2 sl autopsy performed? Yes 2 No certificate 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Pate signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA6+1 Benlin 10445 Ocean City 31. Date filed (Month, Day, 32 Registrar's Signature Year) State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:00P M **Physician** 2009 April 3, Kimberly Marie Schmid /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Mechanics ville 26585 Forest Hall Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 360-58-6127 1 M 2 X February 21,1961 Illinois 48 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be mutified at once. Mechanics ville 1 □ Yes X No St. Mary's **Maryland** Director 10f. Zip Code 20659 10g. Ciu. Citizen of What Country? 10e. Street and Number 26585 Forest Hall Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
St. Mary's County 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Home Hospital Teacher Public Schools Elementary/Secondary (0-12) College (24or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joanne Werner Warren Franklin Strantz ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26585 Forest Hall Drive, Mechanicsville, MD 20659 Peter Schmid/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition April 6, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Charlotte Hall, MD Brinsfield-Echols Crem. 4 □ Ponation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 9 II Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per Jennifer Schmidt, 40900 Merchants Lane, Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 100 0 7 2000 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year 1:30 P M Lydia Swarey April 5, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Charlotte Hall 8060 Beethoven Place If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Hours Davs Months 1 □ M 2 😿 F November 30, 1929 Pennsylvania 215-56-9803 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐Yes 2 No Charlotte Hall Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20622 IISA 8060 Beethoven Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 🔽 If Yes, Give Year or Dates: 2 🙀 No 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home **Komemaker** 7 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lydia Stoltzfus Ben Stoltzfus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte Hall, MD 20622 8060 Beethoven Place Israel Swarey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 8 2009 Mechanicsville, Maryland Fisher Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licer Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.2000 1 ☐ Yes 1 Yes 0 29. Place of Death (Check only one)

Physician /Medical Examiner

Department of Health Important: If Item 27 any Injury or other tr. 900ce.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Pages 1 and 2 should be filed within 72 hours after dearment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items unry or other traumatic event, I'm Medical Examination unry or other traumatic event, I'm Medical Examination.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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death with the Marylan

Examine the burial-trar Physician/Medical attending pl cate has been signed by the page 2 should be detached δ Be Completed certificate funeral director, Certification: To this After 24 hours after death Funeral Director: the filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 25. Was case referent to medical examiner? Hospital: 2200 1 ☐ Yes

1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

ertifying Physician: To the bes my wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the b of ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and m ed.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print)

29015 Three Notch Road Suite 1A Mechancisville, MD 20659

State Registrar

completely

within 2. To the F

Medical

(Month, Day

09-02782 Seville Skinner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 12581

	1- For State Certificate of Death Reg. No.															
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Month							Date of Dea Month	Day	Year		Time of Death 1444 hrs			
dical Examir	ner	Seville M. Sl										April 7, 20	009			1444 nrs
		4a. Facility Name (if not institu			ımber)			4b. City, To		ocation of	Death		- 1	c. County of Dea Wicomico	ith	
		Penninsula Regiona	l Medic	al Center				Salisb							Di sekla sa l	lana (Chaha an
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. last	birthday)	If Unde	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of Bi	rth(MN	M/DD/YYYY) 9. E Fore	aian	1
Director		213-24-0480	1!	M 2X F		80	Yrs		Days	Hours	10,111	April	8,	1928 °	Count	^{ry)} MD
	ŀ	Usual Residence of Decedent													14/	Od. Inside City Limits
any		10a. State 10b. Coun	•		10		own or Local	tion								X Yes 2 No
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faryla	Director	10e. Street and Number						10f. Zip	Code				10g. Ci	itizen of What Co	untry	'?
vith the Maryland s 23a or 28a-f show a enotified at once.		602 Stephen I	Decat	ur Ap	ts.			21	811					USA		
with ns 23 be no	Funeral	11. Marital Status		12. Was De Armed F		ver in U.S.		as Deceder Yes, specify				cify Yes or No	0-	14. Race - Am White, etc.		n Indian, Black,
death or ite	E I		Married	1 Yes	2 2	X No						, , , ,		D1	t	a.
after	by F			If Yes, Give Ye or Dates:				Yes 2					1465	Specify: B		
nours	be l	15. Decedent's Education (S					6a. Decede during r	nt's Usual (nost of wor	Occupationships Coupation	on (Give ki DO NOT u	ind of wo use retire	rk done d)	100	, King of Busines	,5/ H IQ1	ustry
6 n 72 l	Completed	Elementary/Secondary (0-1	2)	College (1-4 or 5+	⁾			Cook				-	Resta	2117	ent
within itene.	Ē	11 17. Father's Name (First, Midd	la Last)		_			<u> </u>			Name (First, Middle.	Maide	en Surname)	Į di	- I
215-0036 be filed within 7 ral Hygiene. rked other than ent, the Medica		Elwood Fooks										urgis		,		
212 ould be I Menta marke	o Be	19a. Informant's Name/Related					19b. Mailir	ng Address	(Street				ımber,	City or Town, St	ate, Z	(ip Code)
Shou and N 7 is n	F	Peggy Briggs			/		1					DE 1)
and 2 sealth tem 2 traur		20a. Method of Disposition					ace of Dispo	sition (Nan	ne of cem			Date		c. Location - City	or To	own, State
Ore		1 X Burial 2 Crema	ion 3	Removal	from State		ematory or d			tanz	04/1	1/200	al	Berlin	M	TD
ti. Pag trnent		4 Donation 5 Other	Specify.												, 11	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If viem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Serv	r Ce ucens	A Asr			Ĺ	ewis	N. W	atsor	Fur	neral 1	Hom	e, PA		
		21. Signature of Funeral Serv	or compl	lications that	caused th	ne death. D	Do not enter	the mode	est of dying, s	such as ca	Sa Li ardiac or	respiratory a	rrest, s	shock, or heart	\neg	Approximate Interval
Physician /Medical		failure. List only one cal	ise on ea	cn line.										disease		Between Onset and Death
xaminer		Immediate Cause (Final dise or condition resulting in death		Due to (or as				Jacie.	LOCIO	car	ulov	abcar		4150450		
		Sequentially list conditions,	b.												4	
	ner	if any, leading to immediate cause. Enter Underlying Cau		Due to (or as	a consec	quence of):	:									
	Examiner	(Disease or injury that initiate	d C	Due to (or as	a consec	uence of):	:								\dashv	
ansit		events resulting in death) La	d.	·					_							
3ox 68760, death certificate be executed the attending physician and I for use as the burial - transit	/Medical	X UNPENDED		AMENDED	23a,	27,p	erME,	g890	4/23	3/09	TT					
760, ficate be g physic the buri	Med	IF FEMALE:		23c. If yes	s, outcome	e of pregna	ancy							23d. Date of deli		
687 certifica nding p		23b. Was decedent pregnant past 12 months?	n the	1 Live	birth		2 F	etal death		Ectopic	c pregnar	псу	}	Month	Da	ay Year
Box (e death ce the attended for use	Physician	1 Yes 2 ✔ No 9	Unknown		gnant at t nown	ime of dea	oth 5 (Other (Spe	ecify)							
	l y	Part II. Other significant co	nditions			but not res	sulting in the	e underlyin	q cause g	iven in Pa	art I.	23e. Did	tobac	cco use contribute	e to th	ne cause of death?
Records, P.O. Box 68' The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as	ģ						_					1 🔲 ነ	es 2	2 No 3	Proba	ably 4 🗸 Unknown
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Corc law re has be	월											pe	topsy rforme	d? deat	th?	ompletion of cause of
Rec The I cate I page	5											1 ✓ Ye	s 2	No 1 ✓	Yes	8 2 No
tal Rection: The certificate ector, page	Be (25. Was case referred to me examiner?		lospital:						of Death Other			_ Doc	sidence 6 C	Other:	
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should t	2	1 ✓ Yes 2 No			Inpatier		ER/Outpatie		DOA	ry at Worl		g Home 5		injury occurred	Allei.	
n of ling Pl After funera	Ë	27. Manner of Death		(Mor	te of Injur nth, Day,Ye	ear)	Zob. Time C	n injury		Yes 2	-	200. 2000		,,		
sior ttend death ctor: y the	iặi	3	Pending nvestigati	ion			121					28f Location	n /Stre	et and Number o	r Rur	ral Route Number, City
Division lal or Attendi rs after death al Director:	Certification:		Could not determine	be		ury - At no	me, farm, st	reet, factor	y, office t	Juliaing, e	ic.	or Town				a
Division of Vital Hospital or Attending Physician: 43 hours after death temeral Director: After this certif tely filled in by the funeral director.		4 Homicide		(-)					- 4	-10 000 01		due to the c	01100/0	and manner as	state	d
Divis To the Hospital or / within 24 hours after To the Funeral Dire	ca	(Check only one) Certifyir	g Physic Examine	ian; To the b r:On the basi	est of my is of exan	r knowledg nination ar	ge, death oc nd/or investi	curred at th gation, in m	ie time, da ny opinior	ate and pr n, death of	ace, and courred a	t the time, da	ate and	i) and manner as d place, and due	to the	cause(s)
To the within 2 To the Complet	Medical	29b. Signature and title of ce		and manne	r stated.					e number				9d. Date signed		
	-	2 Sb. Gignature and title of Ce	11	1.11	- 46				O.C.				1	April 8, 2009		
		Yeungh)	Wh	WIN	NO.	onth /lt-a-	2327									
_		30. Name and address of pe Pamela E. Southa		Assistar	ause of di nt Medi	eatri (item cal Exar	zəa) miner '	111 Pen	n Stree	t, Baltir	nore, N	/ID 21201				
						r's Signatu										
\$	itate	A PR	12	2000	Beer		A J	back								

			For	epartment of Health and Menta Certificate of Death	Reg. No 2009 12582
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Mo	tte of Death onth Day Year 3. Time of Death
	/Medic	al	Marizetta Scott	4b. City, Town, or Location of Death	ril 13, 2009 7:05A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 6103 Elmendorf Drive	Suitland	Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. 8 Da	ate of Birth 9. Birthplace (State or Foreign Country)
	Director		5/8-52-2490 12		.27,1937 Wash.,DC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Maryl	ţ	MD PG Sui	tland	1⊠ Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with		6103 Elmendorf Drive	20746	United States
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be nutified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican, 1 □Yes 2√√2 No Specify:	es or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
9	2 hour		15 Decedent's Education 16a (Decedent's Usual Occupation	16b. Kind of Business/Industry
215	I within 72 ho jiene. r than "natui in Medice I	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working life. DO NOT use retired)	
2	filed wit Hygien other th			nagement Analyst	Government t, Middle, Maiden Surname)
and	tal d c	a	17. Father's Name (First, Middle, Last)		
Z	s 1 and 2 should be f Health and Ments item 27 is marked other traumatic ev	은	Lewis Harrison Sr 19a, Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural Rout	e Russell te Number, City or Town, State, Zip Code)
Z	1 and 2 s Health ar em 27 is ther trau		Steven Scott/son 61	03 Elmendorf Drive	
re,	es 1 al of Hei fitem rothe		20a. Method of Disposition 20b. Place of cemetery	03 Elmendorf Drive itland, MD 20746 Disposition (Name of commatory or other place) 4/16/09	20c. Location - City or Town, State
Ē	nit. Pages artment of ortant: If it injury or o			ale Park Crematory	Riverdale, MD
Baltimore, Maryland 21215-0036	permit. Page Department Important: If any injury o		21. Sign fur of Funeral Service Licensee	^{22. Name and Address of Facility} Hodge 3910 Silver Hill Rd	es & Edwards F.H. d., Suitland, MD. 20746
	v		23a/Pay1. Enter the disease, or complications that caused the death. Do no phock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or resp	oiratory arrest, Approximate Interval Between Onset and Death
-	Physician			DISERSE	
	/Medical Examiner		resulting in death) Due to (or as a consequence or	nis ens	
	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ja	Sequentially list conditions, if any leading to immediate	ly.	
	uted 5 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
oʻ	e exec an an	Exa	resulting in death) Last Due to (or as a consequence or	r):	
68760,	ificate be executed g physician and as the burial-transit	edical	d		
		Med	IF FEMALE:		2012000000000
O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
٠, ص	w requires that the desired should be detached	by Pt	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ğ	equires en sig vuld be	ed b			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
of Vital Records,	he law re te has be- age 2 sho	Completed			24a. Was an autopsy performed? □ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
ita	ding Physician: The n. After this certificate h funeral director, page	BeC	25. Was case referred to medical	26. Place of Death (Che	
f \	hysic this ce al direc		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	·	5 X Residence 6 □ Other (Specify)
פע	ding Pl J. After t funera	ü	Zivatural 5 Felicing	njury Work?	Describe how injury occurred
Division	ttend death. tor: /	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, far	M 1 □ Yes 2 □ No m, street factory office 28f, Li	ocation (Street and Number or Rural Route Number,
Σ	after of Direct In by	ertif	4 Homicide determined building, etc. (Specify)		City or Town, State)
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place, and d d/or investigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
	To the within To the Somple	Med	29b. Signature and title of contifier	29c. License number	29d. Date signed (Month, Day, Year)
			1// lans	- MO12134	4/15/2009
			30. Name and address of person who completed cause of death (Item 23a) (7 7/ 2	7
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	SERVINGST NW L	JC. 600 (0
	St Regist	ate rar	ADD 2 0 2000	hade	

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 2583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2009 Lee Taylor Donald /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 15 Hospice MIC 11 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Hours Months Days Min 1**X** M 2□ F 71 220-32-5003 Jun 28, Virginia Director 1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once. Director 1 ☐ Yes 2 X No MD Ocean City Worcester 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21842 USA 10618 Pine Needle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White USAR. 1 ☐ Yes 2 No Specify: Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12College (1-4or 5+) USPS Postal Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor Clayton ည Dwight L. Kathryn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Taylor (wife) 10618 Pine Needle Road Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr 6 1 Se Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2009 Brentwood, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee Gary J. Goff 8125 Southern Maryland Blvd Owings. MD 20736 Party Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** zheimers /Medical Due to (or as a consequence of): Examiner inothumidis Sequentially list conditions, if any, leading to infried attacase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to f it as a consequence of) sician and burial-transit Attending Physician: The law requires that the death certificate be executed SeNIAN Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certificietely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6-Dother (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the I within 2

State Registrar

Signature and title of certifier

- Bergmye hrun ller 31. Date filed (Month, Day, Year) 32. Registra s Signature APR 03 2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

10

29d. Date signed (Month, Day, Year)

Certificate of Death

Rea. No.

Da

2009

4c. County of Death

1914 Michigan

14. Race - American Indian Black, White, etc.

Specify: White

23d. Date of delivery

Day

No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

April 3, 2009

Calvert

12:45 A.M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

2. Date of Death

1. Decedent's Name (First, Middle, Last)

Physician

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

APR 03 2009

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gwyneth A. Blattau, MD

D58572

14090 Solomons Island Rd., Suite #2500, Solomons, MD 20688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02920 Dawn Taylor State of Maryland / Department of Health and Mental Hygiene 2009 12585 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Time of Deatl Decedent's Name (First, Middle,Last) Physician/ Month Day April 12, 2009 0840 hrs **Medical Examiner** Dawn Liv Taylor c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number St. Marv's Leonardtown 23555 Brown Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months Days Director FL590-98-7074 05/12/1990 $^2\mathbf{X}^F$ M 18 Usual Residence of Decedent 10d. Inside City Limits iny 10a. State 10c. City, Town or Location Yes 2 X No Hagerstown 28a-f show Washington MD items 23a or 28a-f shornst be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US 21740 318 Landis Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes if Pages 1 and 2 should be filed within 72 hours after d riment of Health and Mental Hygiene. Transit: If item 27 is marked other than "matural", or yor other traumatic event. As we were White Yes, Give Year Yes 2 X No specify: Specify Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/AN/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn Marie Glover Jeffrey James Taylor Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 318 Landis Road, Hagerstown, MD 21740 Jeffrey J. Taylor / Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 04/18/2009 Smithsburg, MD portant: Smithsburg Crematory Other Specify: Donation 5 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Methadone intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical 23a,27,28a-f, per ME g891 5/14/09 TT X UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown 9 Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö þ Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 ✓ Yes 2 No 26.Place of Death (Check only one To the Hospital or Attending Physician: 25. Was case referred to medica **Division of Vital** Be Other₄ examiner? Hospital: 1 Residence 6 Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 2 this ٩ 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 X No Pending Director: Fd 4/12/09 Fd 0830 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 23555 Brown Rd Leonardtown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide residence determined (Specify) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State 31. Date filed (Month, Day, Year).
Registrar APR 15

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of deat

Russell Alexander MD.



(Item 23a)

April 13, 2009

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Betty T. Turner HPRI /Medical 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number Examiner HARLE lata EDICAL ENTER 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Cuba 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Davs Months 1 □ M 2 🖫 F 225-80-7447 76 August Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Exactinet must be modified at 1 ☐Yes 2 No Director MD Charles Port Tobacco 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6937 Glassgow Lane 20677 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Kares 2 No Cuban Specify: Specify: Other \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Fredesvinda Betancourt ပ Juan Sastre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 Robert Turner/son , MD 6937 Glassgow Lane, Port Tobacco 20677 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Brinsfield-Echols Crem. 4/7/09 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sun al Service Li 2AREHARITECHOLS FUNERAL HOME, P.A. M01458 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of nece monia Examiner Sequentially list conditions Due to (or as a consequence of) If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aftending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 II Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 🗍 Nursing Home 5 🗎 Residence 6 🗎 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After t n 24 hours after death.

The Funeral Director: After the further t Medical

Maryland 21215-00

timore,

Certification: To Date of Injury (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

000

npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

6 2009

101 Waldorf, MD 1057

State Registrar

completely

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2 6:15 P^{M} April 2009 Johan C. Vermeulen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Ellicott City Nursing & Rehab Ellicott City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 XM 2 □ F Feb 14, Indonesia 79 1930 004 36 0711 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 □Yes 2 TXNo Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number United States 21043 3570 Courthouse Road Apt 2C 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify. White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Defense Contractor Space Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johannes Simon Vermeulen Hendrika Jacoba de Vrdedt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11920 Mid County Drive Monrovia, MD 21770-9439 Sandra Jo Sauerwein/Step-Dau. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hanover, MD Ardent Crematory 4-3-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Gllmi 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACCIDENT CEREBROUASCULAR Due to (or as a consequence of): ATHEROSC LEROTIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

item 27 other t

Department of H Important: If iter any Injury or oth once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ther traumatic event, the "walfical Examinar must be notified at

1 and 2 should be filed within 72 hours after

Pages 1

Baltimore, Maryland 21215-0036

Examiner burial-trar physician Physician/Medical the attending p for use as 1 þ certificate has been s rector, page 2 should Completed Be Certification: To After t funera ours after death neral Director: / filled in by the f

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTEWSION 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

00053150

sentago Rd

April 3, 2009

MO

21045

thin 24 hours at the Funeral D

within 24

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

9650 PYC

			1 - State of Maryland / Departing State of Maryland / Departing Certific	cate of Death	nentai myg F	Reg. No. 2009	12588
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	nth Day Year	3. Time of Death
	Physici /Medic		LENA GERTRUDE WITT		03	25 09	0353 ^M
-	Examin			City, Town, or Location of Death		4c. County of Deat	
-			WMHS BRADDOCK CAMPUS	CUMBERLAND Under 1 Year If Under 24 Hrs.	O Data of Diet	ALLEGAN	
	Funeral Director			nths Days Hours Min.	8. Date of Birth (Month, Day 9-13-1	v, Year) Co	hplace (State or Foreign untry) MD
	land		10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
	Mary F sh	ρ̈́	PA Somerset Meyersdale				1 K∏Yes 2 □ No
	r 28a	irec		f. Zip Code	T .	10g. Citizen of What Co	untry?
	3a o	Funeral Director	1137 Shirîey's Hollow Rd	15552		USA	
	deat rms 2	ner		Decedent of Hispanic Origin? (Sp, specify Cuban, Mexican, Puerto	ecify Yes or No-		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Madical Externing Institute be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼No	es 2 MNo Specify:	Thour, etc.)		WHite
5-0	72 ho natur	etec	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of the completed)	S Usual Occupation of work done during most of work OT use retired)	ing 1	16b. Kind of Business/	Industry
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Maryland	2 should be fand Mental I is marked of aumatic ever	ရ		dress (Street and Number or Rur			Zip Code)
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ē,	s 1 and 2 if Health item 27 i	11 6	20a. Method of Disposition 20b. Place of Disposition	-	Date	20c. Location - City or	Town, State
E	Page nent c int: If		1		-2009	Wellersbur	g, PA
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service License 22. Nar	me and Address of Facility Har Inc 169 Claren	vey H.	Zeigler Fur	neral
	_		23a. Part1. Inter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	Si i	Immediate Cause (Final	Fringer			Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	VF. Culput			
	Examiner		b ASCVD				
	D #=	ner	Sequentially list conditions, If a my leading to translate cause. Enter Underlying Cause (Disease or injury that initiated events				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events constituting in death) Last Due to (or as a consequence of):				
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P.0.	Physician: The law requires that the death cer r this certificate has been signed by the attendin ral director, page 2 should be detached for use.	Physician/IV	9 ☐ Unknown	er (specify)	00 - Pill		the second death O
တ်	res th signed	þ	Part II. Other significant conditions contributing to death but not resulting in the underly	/ing cause given in Part I.		obacco use contribute to ⁄es 2□No 3⊠P	robably 4 Unknown
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Records,	e law has b je 2 sl	Completed	Upper 61 Black		24a. Was autop	sv prior to	utopsy findings available completion of cause of
a	r: Th ficate r, pag					2√No 1 □ Yes	2 □No
Ζ	siciar certii recto	Be	25. Was case referred to medical examiner?	26. Place of Deat			
o To	Physical distribution	To	1 ☐ Yes 2 ☐ No 105 Internation 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of	☐ DOA		dence 6 Other (Spenow injury occurred	ecify)
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<u>Visi</u>	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office	28f. Location (S	Street and Number or R	ural Route Number,
Ö	salor safte al Dir	Certification:	4 Hornicide Building, etc. (Specify)		City or Tow	vii, Statej	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) One) Certifying Physician: To the best of my knowledge, death occ the basis of examination and/or investig and manner stated.				
	Fo the vithin Fo the Fo the Formula to the Formula For	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	th, Day, Year)
	4		> /> /mhe	D42054	6	March.	25, 2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 . 0	1	March.	7
	MRS		DR. Grega DONALDSON 912 Seton	DRIVE, Comk	erlanc	d, IIID ar	502
	Sta		31. Date filed (Month, Day, Year) NAR 27 2009 32. Registrar's Agnature and San				
	Regist	ar	HULL ST. TATE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:15 P M 8 April 2009 Ward Geraldine Virginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland 1030 Myrtle Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 85 12/19/1923 Marvland Director 215-20-6763 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 □ No Director MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1030 Myrtle Street 21502 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Photography Studio Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental f Pages 1 and 2 should be Pearl Ginivin Anna Charles Lorenzie Bradv ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 I 1030 Myrtle Street, Cumberland, MD Philip W. Ward / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or oth 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 04/11/2009 LaVale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service Licensee loans 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** on umon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed and as the burial-trar resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Othe Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to mpietely filled in by the funeral director, page 2 to a second to the control of the control autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1□Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medignt Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s). 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D33280 April 9, 2009 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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State

625 Kent Avenue, Cumberland, MD

M.D.,

32. Registrar's Signature

K. Gupta,

Sunil

31. Date filed (Month, Day, Year) APR 0 9 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

PHY G890 4/24/09 JH
State of Maryland / Department of Health and Mental Hygiene amend #23a Per Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 1, ^{Day} 2009 Physician 1:20 p Eugene Walls Benjamin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles Waldorf 4590 Bryan Meadows Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F April 26,1940 Washington, DC 68 Director 216-38-6243 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at 1 ☐ Yes 2 XNo Director Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 USA 4590 Bryan Meadows Lane death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Exertines any Injury or other traumatic event, the Medical Exertines once. Armed Forces 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Florist** 12 Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Richard Walls Mary Emma Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4590 Bryan Meadows Lane, Waldorf, MD 20601 Valerie A. Walls/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Trinity Memorial 4/06/2009 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Furjeral Service Licenses M00817 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Diffuse Large B Cell Lymphoma Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to ininterdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: s certificate ha irector, page 2 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🖳 👭 o 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 V Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifique 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LaPlata, Maryland 20646 Krishan Mathur, M.D. 31. Date filed (Month, Day, . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 4, 2009 5:20 p ^M Percenette Wilkinson, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Leonardtown St. Mary's 23770 Dry Docking Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days 101 20, 1907 Maryland 213-10-9776 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Leonardtown Maryland St. Mary's 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours atter death with USA 20650 23770 Dry Docking Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2★ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No 'natural", or Specify: à 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Electronic_ Technician Self Employed 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wells Wilkinson, Sr. Eleanor မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph A. Wilkinson/Son 40204 Folly Cove Lane, Leonardtown, MD 20650 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important; If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/08/2009 Hollywood, MD St. John's 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Failure to Thrive 6 mos /Medical Due to (or as a consequence of): Examiner Parkinson's Disease <u>5 yrs</u> Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ום Hospica. -n 24 hours after death. he Funeral Director: Af within 2.

Certification: To Medical

State

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 729c. License number

04/07/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Šcott Tidball, M.D.

2050 Wildewood Shopping Center, Hollywood, MD 20636

D22196

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32 Registrar's Signature

and manner stated.



Registrar

	1	State Registrar		Cer	tificate of	Death		Reg. N	· 200°	9 12592
Physiciai /Medica	n	1. Decedent's Name (First, Middle, Las Janet L -	Willis				2. Date of Domestil	C	Day Year 2009	3. Time of Death 10:42
Examine		4a. Facility Name (If not institution, giv 221 Sandcastle	Road		4b. City, Town, o Fruit	land			c. County of Dea	0
Funeral Director		5. Social Security Number 217–34–5209 1 Usual Residence of Decedent	ex 7. Age (In yrs. las 72	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	8. Date of Bi (Month, D	a <i>y, Y</i> ea	r) Co	thplace (State or Foreign ountry) aryland
e Maryland Ba-f show	ctor	10a. State 10b. County Maryland Wicomi		own or Loc uitlar	nd					10d. Inside City Limits 1 ☐ Yes 2 ☐ X Io
th with th	Funeral Director	10e. Street and Number 221 Sandcastle	Road		10f. Zip Code 21826	5		10g. (Citizen of What Co USA	ountry?
Irs a	≥∣	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		/as Decedent of H Yes, specify Cub ☐ Yes 2 ★No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
within 72 huiene.	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occup ind of work done O NOT use retire emaker	oation during most of v d)	working	16b.	Kind of Business domest	·
uld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) George Reidel				18. Mother's N Ida	Name (First, Middle Devall	e, Maide	en Surname)	
and 2 sho alth and 27 is me er traums		19a. Informant's Name/Relationship (Kenny Reidel/so	Type. Print)	27565	Address (Street Dirby	and Number of Sal	Rural Route Num Lisbury ,	MD ^{City}	21801 State,	Zip Code)
Pages 1 and the nort of He nort of He nort of He nort: If item iny or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	Hemoval from State		ition <i>(Nam</i> e of atory or other pla y Cremat	4	Date 3/09		Location - City or	
permit. Departm Importa any inju		21. Signature of Funeral Service Licer								Association 1804
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line.	Do not ente	r the mode of dyi	ng, such as card				Approximate Interval Between Onset and Death
/Medical Examiner	_	Sequentially list conditions	a. Due to (or as a consequer b. Is demi		hongy	ソ				Year.
certificate be executed ding physician and se as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,						
ifficate be ey g physician as the burial	/Medical	•	d							
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 🗆	Ectopic pregnand Other (specify) _	СУ			23d. Date of de Month	olivery Day Year
uires that the signed by the detaction of the detaction of the detaction of the detaction of the signed by the sig	2	Part II. Other significant conditions of	hali in	ng in the un	derlying cause giv	ven in Part I.				o the cause of death? Probably 4 Unknown
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Completed	Mitala	zvzejaln				24a. Wa aut pen 1 □ Yes	opsy formed?	prior to	utopsy findings available completion of cause of
ian:	Be C	25. Was case referred to medical examiner?				26. Place of I	Death (Check only			
hysic his ce I dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF			4 ∐ Nursin	g Home 5 ☑ Res	sidence	6 ☐ Other (Spe	ecify)
tending P leath. tor: After the funera	Certification:	27. Manner of Death 1/★Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	(Month, Day, Year)	Bb. Time of Injury		ryat k? IYes 2 □ No	28d. Describe			
urs after of ral Direct illed in by		4 Homicide determined	building, etc. (Specify)				City or To	òwn, Sta	ate)	Pural Route Number,
the Hosp hin 24 ho the Fune Tipletely f	Medical	(Check only 2 Medical Examone)	nysician: To the best of my knowledge. niner: On the basis of examination and manner stated.		estigation, in my	opinion, death o		e, date a	and place, and du	e to the cause(s)
5 With S	4	29b. Signature and title of certifier	mj.			MMOF.	3		Date signed (Mon	
32,		30. Name and address of person who	(w) 10	6	M LLGru	0 46	0), 2	MI	som M	y 21804
State Registra		31. Date filed (Month, Day, Year) APR 0 3	32. Registrar's Signatur		bad	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 15, 2009 John W. Austin, Jr. 1:30am 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 2607 Chapel Lake Drive #412 Gambrills 8. Date of Birth (Month, Day, Year) May 26, 1935 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Min. 1 XM 2 ☐ F Months Days Hours Maryland 220-30-6589 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 24 No Maryland Anne Arundel Gambrills 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21054 2607 Chapel Lake Drive #412 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maryland Glass Corp. Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ball Austin, Sr. Elizabeth W. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Chapel Lake Drive #412 Gambrills, Maryland 21054 Barbara A. Austin (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 04/20/09 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. B2O4 Mountain Road Pasadena, Marvland 21122 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Due to (or as a consequence of): IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown edent pregnant st 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1∐Yes 2∭ZNo 1 ☐ Yes 2X No 25. Was case referred to medical 26 Place of Death (Check only one)

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Funeral Director

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Completed

Be

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John

Examiner

Funeral

Director

the Marylan

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be undiffied at once.

Baltimore, Maryland 21215-0036

been signed by the should be detached s certificate has be irector, page 2 s Director: Medical

Examine Physician/Medical Completed by Be Certification: To 27

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⊒Yes 2 □No 9 Unknown

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examiner? 1 ☐ Yes 2 🕱 No		Hospital:	1 ☐ Inpatient	2 🗆	ER/Outpatient	3 🗆 [DOA C	Other: 4	□ Nursing H	lome	5 Residence	6 □Other	(Specify)
2 Accident	5 ☐ Pending investigation		Date of Injury (Month, Day, Ye	ar)	28b. Time of Injury	М	28c. In W		2 🗆 No	28d.	Describe how inju	ury occurred	1
o □ o · · · · · ·													

determined 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number D 16354 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE BALTIMORE MD

and manner stated.

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier



within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03093 State of Maryland / Department of Health and Mental Hygiene Linda Beyer-Swimm 12594 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 18, 2009 0256 hrs Medical Examiner BEYER LINDA ANN 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore None 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1953 Director July 5. Country) Maryland M 2XXF 55 217-54-2816 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X XNo Baltimore Baltimore 28a-f shov Maryland notified at once. with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code USA 21222 102 Delmar Avenue 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. be 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2XX Married Armed Forces must 2XX No Yes Yes, Give Year White Divorced Yes XX No specify. Specify. Widowed marked other than "natural", ic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "n or other traumatic event, the Medical E Baltimore, MD 21215-0036 Veterinarian Caregiver 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Charles Kaptain Frances Ruth Dennis Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |102 Delmar Avenue Baltimore, Maryland 21222 Jeffrey Thomas Swimm Hus 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Dulaney Valley Mem Grdns 1 XXBurial 2 Cremation 3 Removal from State April 22,2009 Timonium Maryland ment c tant: or off Other Specify Donation 5 22. Name and Address of Facility John O Mitchell IV Funeral Services of ignature of Funeral Service Licensee Dulaney Valley 200 East Padonia Road Timonium Maryland 21093 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X AMENDED #1 as noted, 23a,PII,27,perME, g891 5/7/09 TT X UNPENDED the attending physician ed for use as the burial -Box 68760, 23d. Date of delivery IE EEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. þ Yes 2 No 3 Probably 4 ✔ Unknown Chronic obstructive pulmonary disease; Diabetes Completed 24a. Was an 24b. Were autopsy findings available Mellitus autopsy prior to completion of cause of has performed' death? Yes 2 V No Yes 2 No certificate 25. Was case referred to medical 26.Place of Death (Check only one) or Attending Physician: Division of Vital Be Other₄ examiner? Hospital: Other 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient 1 V Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number April 19, 2009 O.C.M.E.

State Registrar

31. Date filed (Month, Day, Year) 2. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Carol Allan, MD

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** an Robert Edward Bullock /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner N/A mayland Greneral If Under 24 Hrs 8. Date of Birth NOV 14, 1938 9. Birthplace (State or Foreign Country) Mary Land If Unde 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F 70 Yrs. 212-36-5062 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r items 23s or 28s-f shov 1 Yes 2 □ No Directo Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1710 North Calhoun Street 21217 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 27 is marked other then "naturel", or traumatic event, the Medical Exar 3 🛱 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Shipping Bullock, Rober 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Mason John Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other traugone. 7005 Plymouth Road Pikesville, Maryland 21208 Aileen Bullock-Adams, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/20/09 Baltimore, Maryland 21. Signature of Funeral Service Lice Cremations Stellety Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage IV Physician Lung cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, To that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 🗆 No Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 2 No 1 Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge death construct at the time, date and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 3

State Registrar

31. Date filed (Month, Day, Year) APR 2 1 2009 32. Registrar's Signature

of Brth 11/4/38

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 355 PM M **Physician** 2009 BOONE JR WILLIAM April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HEALTH REHAB CENTER OVERLEA If Under 1 Year | If Under 9. Birthplace (State or Foreign Country) 24 Hrs. Min. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours 215-28-3404 08/04 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Medical Expanirer mast ke notified at 1 TYes 2 No BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Avenue
12. Was Decedent Ever in U.S.
Armed Forces?
1 GYes 2 No
If Yes, Give
Year or Dates: 21205 Funeral 621 N. Decker 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "na any injury or other traumatic event "". College (1-4or 5+) Elementary/Secondary (0-12) N/A Disabled N/A18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Haskin Bernice Sr. William R. Boone ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Decker Avenue Baltimore, MD 21205 Vernon Wade Boone-son Ν. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State King Memorial Pk.4/24/2009 Randallstown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST H lady E. North Avenue Baltimore, MD 21202 Warner 1101 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. no not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, physician Physician/Medical the SES attending p IF FEMALE 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No ed by the a detached a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DCA 1 🗌 Yes Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation nours after death.

neral Director; Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Kaven State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy a Per division of Health and Mental Hygiene 0 0 9 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11:00 Pm Frank Bianca April 17, 2009 Frank G. Bianca, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Health & Rehab. Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year)
Jan. 21, 1 If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F 216-10-8336 99 1910 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Fifth Ave., S.E. 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔼 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify 3 X Widowed 4 ☐ Divorced White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber Hair Styling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Bianca Marie Brocatto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank G. Bianca, Jr./son 313 Fifth Ave., S.E., Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 22, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 4 ☐ Denation 5 ☐ Other (Specify) 2009 Glen Burnie, Maryland 21. Signalui 2 of Jun vai Sen 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death/ Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Thrive Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, ned by the a edetached fo o Division of Vital Records, P. Sin After death. efter death Director: / filled in by within 24 hours e To the Funeral I the Hospital

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

2 should be filed within 72 hours after deeth with the Maryland is and Mental Hygiene.

Baltimore, Maryland 21215-0036

27 is marked other then "naturel", or freme 23a or 28a-f shov traumatic event, if a Mudical Examinar must be notified at

permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery lipity or other traumatic event SDRS.

Physician /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be 25. Was case referred to medical ၉ 27. Manner of Death Certification: Medical (Check only one) 29b. Signature and title of certifies 29c. License number D-40521 April 20, 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesh Ochaney, M.D., 325 Hospital Drive, Glen Burnie, MD 21061

State Registrar

31. Date liled (Month, Day, Year) APR 2 1 2009



State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Brewn **Physician** Jae1 Everett 18 2009 500 boril /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours 1 X M 2 □ F 2, 1942 Maryland Director 214-40-8689 66 Nov. Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2😨 No Director Florida St. Johns Ponte Vedra Beach 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ò items 23a 125 Cuello Court, Unit #201 32082 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【※No Black, White, etc. 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 XNo If Yes, Give Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Defense Vice President Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 is marked other the states of the st 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joel Brown Lucy Lewis Beall ပ 32082 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 125 Cuello Court, Unit 201, Ponte Vedra Beach, FL Wife Constance Brown 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State St. Johns Cemetery 4/23/2009 Ellicott City, MD Donation 5 - Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Signature of Funeral Service License Funeral Home of Catonsville, Inc. 23a. Part 1. Enter the disease, or cym, lications that raived the deshock, or heart failure. List vily one cause on each line. 1630 Edmondson Avenue: Catonsville,
Do not enter the mode of dying, such as cardiac or respiratory arrest, MD. 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cance luna /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or moury that initiated events Examiner Due to (or as a consequence of) use as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Box 68760 Physician/Medical pe IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown the Division of Vital Records, P.O. 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pneumonia has 2 🗌 No Yes 2 1 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 - ER/Outpatient 3 🗆 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: I or Attending F after death. Director: After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Sung 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 1 2009 Registrar

	•	For State Registr <i>a</i> r	State of Maryl	-	rtificate of			Reg. No.2	09	12599
		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	ath Day	Year	3. Time of Death
Physicia /Medic		Kathleen LoAnne	Brodkin				April		2009	6:00 Р. м
Examin		4e. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	r Location of Deat	th	4c. County	y of Death	
		10713 Faulkner Ridg			Colu	nbia If Under 24 Hrs	1 0 D-1- (D-1		loward	-land (Change Free)
Funeral Director		047-34-9613	Sex 7. Age (In)	yrs. last birthday) 66 Yrs.	Months Days	Hours Min.		y, Year) 1943	Coul	place (State or Foreign ntry) cticut
M	ŀ	Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	cation				1	10d. Inside City Limits
t sho	ō	Maryland Howard		Columbi	2					1 □Yes 2 No
Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Director	10e. Street and Number		COLUMBI	10f. Zip Code			10g. Citizen of	What Cou	ntry?
23a o		10713 Faulkner	Ridge Circle		21044			U	S.A.	
ems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce · Ameri	
ral", or items 23a or 28a-f show Examinet must be notified at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 □Yes 2 🙀 No	Specify:		Specia	fy: Wh	ite
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- 68	Completed	(Specify only highest of Elementary/Secondary (0-12)	college (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of wo d)	rking			
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te le	Be (17. Father's Name (First, Middle, La	st)				me (First, Middle,	Maiden Surnai	me)	
marked	မှ	Harry Roberts					n Neagle			
7 is n traun		19a. Informant's Name/Relationship Peter Brodkin (H	(Type. Print) Tusband)		ng Address <i>(Street</i> Faulkner F			-		
item 27 is marked r other traumatic e		20a. Method of Disposition			sition (Name of matory or other place		Date	20c. Location		
Important: If ite any injury or ot once.		1 X Burial 2 ☐ Cremation 3	XI Removal from State	cemetery, crei Wooster Ce		(4-24-		Naugatuc		
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ysician Medical aminer	_	23a. Part 1. Enter the isease, or coshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	y one cause on each line. a. Due to lor as a con b.	sequence of):	er the mode of dyff	ng, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between Onset and Death YK Aug
physicia the bur	edical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2+2No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	ey			ate of deliv	very Day Year
	by P	Part II. Other significant conditions	,	_	nderlying cause giv	en in Part I.	23e. Did to	obacco use cor	ntribute to t	the cause of death?
s been signers signers		Obesity,	hypothyrord	m			1 🗆 1	res 2□No	3☐ Pro	bably 4 Unknown
page 2	Completed								. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 3 DOA Oth	or:	ath (Check only o			
r this ral di	5.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	. O DO//	4 🗆 Nursing i	Home 5 Resident			ify)
To the Funeral Director; After this certific completely filled in by the funeral director, I	Certification:	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	(Month, Day, Yea		M 1□	ḱ? [™] Yes 2 □ No		Street and Num		al Route Number,
ial Dir	Cert	4 Emonitoria	Donaing, cic. (Op				Only of You			
ne Funei oletely fil	Medical		Physiclan: To the best of my aminer: On the basis of exal and manner stated.							
To th	Me	29b. Signature and time of certifier	1		29c. Licens	21461		29d. Date sign		Day, Year)
0		30. Name and address of person where Parry A. Moore, M.D.			Print)	,	/amala=1 01			
Cla	10	31. Date filed (Month, Day, Year)	32. Registrar's S		ZUI ELLIC	ice office l	Maryland 21	.042		
Sta	to.	JI, Date filed (Month, Day, Year)	3∠. negistrar's S	griatufe						

ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day 2009^{Year} Washington Harding Basye 14 11:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Atlantic General Hospital 8. Date of Birth (Month, Day, Year) April 4, 1913 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Sex 1 M 2 □ F Months Days 577-10-5132 96 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Silver Spring Montgomery Maryland 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 14800 Pennfield Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 🗶 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Harding William F. Basye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14800 Pennfield Circle # 305, Silver Spring, MD 20906 Dorothy F. Basye 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, Inc. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial , 2XXCremation 3 ☐ Removal from State 04/18/2009 Glen Burnie, Maryland 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
Fleck Funeral Home, Inc.,
7601 Sandy Spring Road, Laurel, MD 20707 Funeral Service License 21. Signature d ebec 23a. Part 1. Enter the disease or complications to shock, or heart failure. Ust only one cause or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due lo (s a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off. Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner 7009 burial-tran and 68760, been signed by the attending physician should be detached for use as the buria o ۵. Records, cate has l After this certificate Division of Vital r Atter ding Physician:

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d other than "natural", or items 23a or 28a-f shorevent, the Medical Evanings must be notified at

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permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any Injury or other trau

Physician

other traumatic

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72 hours after

Baltimore, Maryland 21215-0036

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Washington

completely filled in by the funeral 24 hours after dea Funeral Cirector

> State Registrar

(Check only one) 29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 ☐ Could not be

determined

1 🗹 Certifying Physician: ז the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Tryanner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Mamer and address of pe

Begistrar's Sin

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 200 9 April **Physician** 01:24AM mear rieda /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Harbox 105 pita Baltimon If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV• 14, 1924 5. Social Security Number 216-80-5774 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 💢 F 84 Months Mary 1 snd Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 □ Yes 2 XNo Director Maryland Hanover 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 7110 Ridge Rd. 21076 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 □Yes 2 No White altimore, Maryland 21215-0036 Specify: Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Itel Myonce. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence A. Fisher Edna Dehn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert S. Bealmear, husband 7110 Ridge Rd. Hanover, MD. 21076 Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park 04-20-09 20c. Location - City or Town, State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Ŕd. Arbutus, MD. Approximate Interval Between Onset and Death 23ar Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rreumonia one worth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Kyphoscoliusis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 1 □Yes 2 ₺ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Hamad



S. Hansver

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

29c. License number

Butmone, MB

29d. Date signed (Month, Day, Year)

, 15,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month JoAnn Briggs 4:03 рм 17 2009 April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 507 S. Hammonds Ferry Road Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/13/1943 Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1 □ M 2X F 66 Arkansas 230-58-0385 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Anne Arundel Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 507 S. Hammonds Ferry Road United States Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care/Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victory Sandridge Coleman Bernie Sandridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jerome E. Briggs (Husband) 507 S. Hammonds Ferry Road, Baltimore, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 04/21/2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) of Funeral Service Lice 22. Name and Address of Facility 21. Signaturs Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) one week Due to (or as a consequence 1) three months nown

Physician /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

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Completed

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Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Markal Examiner must be notified at

permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important; If item 27 is marked other i any injury or other traumatic event, III

72 hours after death with the Maryland

3altimore, Maryland 21215-0036

burial-trar physician as attending properties for use as page 2 should

Examiner

Physician/Medical þ Completed Be (

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUSTIN SOMERVILLE

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, t Certification: To Medical

State Registrar

cause. En Cause (Dis that initiate	Sequentially list conditions, rany, leading to infrinded acuse. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.								
in the 1 □ Y	E: decedent pregnant past 12 months? es 2 MNo Jnknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	al death 3 🗆 Ectopic			23d. Date of deli Month	very Day Year		
Part II. Oth	er significant conditions of	nons throw	ulting in the underlying	cause given in Part I.		use contribute to	the cause of death?		
-					24a. Was an autopsy performed? 1 ∐Yes 2 ☑N	prior to death?	topsy findings available completion of cause of 2 No		
25. Was ca	ase referred to medical			26. Place of Dea	ath (Check only one)				
1 ☐ Ye	s 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manne 1 ☑ Na 2 ☐ Ac	Fof Death atural 5 ☐ Pending ccident investigation	28a. Date of Injury (Month, Day, Year)	ry 28b. Time of 28c. Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No						
3 □ Su 4 □ Ho		28e. Place of Injury - At he building, etc. (Special	28f. Location (Street and Number or Rural Route Number, City or Town, State)						

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

25 CROSSROADS DR #312 OWINGS MILLS, MD

29c. License number

D00 62808

29d. Date signed (Month, Day, Year)

21117

2009

APR 2 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

/32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 April 11:45 P M 17 <u>Dorothy Elizabeth Byerley</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edenwald | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Year | Sept. 29,1920 Towson 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2**X**□ F Maryland 216-14-0074 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Towson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 800 Southerly Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ∐Yes 2 📉 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Md. General Hospital Medical Records Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bastian Marie Ε. Τ. Byerley John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3645 Elm Ave. Baltimore, Md. 21211 Jennifer Tittsworth / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Western Cemetery 4/21/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Ch 23a. Part 1. Enter the disesse, or complications that occused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years disease or condition resulting in death) Due to (or as a consequence of): due to organic Brown syndrame 104 Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEART Disease 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Othe 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

10

Director

Funeral

<u></u>

Completed

Be

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Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Woolcal Expr., but it us be inclined as

Baltimoré,

within 24 hours after death
To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 88760

Physician/Medical þ Completed Be Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

Brown (Adokanomit

r;	4 Nursing H				6	6 □Other
		00.	-	 		

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

and manner stated.

armerly Road

State Registrar

within 2. To the F

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:25PM BROCKMAN 2009 KASEY April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** & BALTIMORE BALTIMORE N/A Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/07/1996 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Hours Min. Months Davs 215-47-8976 12 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It is Medical Examiner must be negliged at 1 □Yes 2 KINo Funeral Director BALTIMORE COCKEYSVILLE MD death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21030 12207 FALLS ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2 No WHITE 3altimore, Maryland 21215-0036 Specify: Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be f Health and Mental **BROCKMAN** MELANIE FDF11 RICHARD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 Is I
any injury or other traus 12207 FALLS ROAD, COCKEYSVILLE, MD RICHARD BROCKMAN / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 04/19/2009 REISTERSTOWN, MD Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility of Fundral Service Licensee Signatu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, occamplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 72 kg. Immediate Cause (Final Progressive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner aravan Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-tra Due to (or as a consequence of): physician Box 68760 Physician/Medical th, attending physical for use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 5 ☐ Other (specify) Ö 9 Unknown signed by the best of the sign law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ★ Inpatient 2 □ ER/Outpatient 3 □ DOA this Certification: To After the 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 10 29b. Signature and title of certified MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Baredon Avenue Lickerbe SINAL HOSOITCE Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Brakman, Kasa

2+ Known

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CARTER, JR WILLIAM APRIL 18 2009 6:12 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS-BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F Director <u> 247-24-5769</u> APRIL 22,1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Experiment must be recitifed at Director 1X Yes 2 No MD BALTIMORE TURNER STATION 10e. Street and Number 10g. Citizen of What Country? Funeral 252 CHESTNUT STREET 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. þ Specify 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 721 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Inspine. CUSTODIAN BOARD OF EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ WILLIAM CARTER, SR. ELOUISE WILSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISRAELLA CARTER/WIFE 252 CHESTNUT ST. BALTIMORE, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 📆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) APRIL 21,09 BALTIMORE, MARYLAND METRO CREMATORY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Organization of that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) P.O. the detached signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2: autopsy performe 1 ☐Yes 2 No 1 □Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**6** Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D0028684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Brywew reducal Center 31. Date filed (Month, Day, Year) State Registrar

09-02996 Carol J. Caramango Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ol J. Carama		1- For State Certificate of Death	Reg. No. 2009 1261						
Physicia	an/	Registrar 1. Decedent's Name (First, Middle, Last) Carol J. Caramagno	2. Date of Death Month Day Year April 14, 2009 3. Time of Death 2315 hrs						
dical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local	ation of Death 4c. County of Death						
,		3102 Teal Lane Bowie	Prince George's Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
Funeral Director	٠	1.5 Social Security Number 16, Sex 7, Age (III yis, last bitting)	Hours Min. Aug 26, 1930 Shirthplace (State or Foreign New Jersey)						
=		Usual Residence of Decedent	10d. Inside City Limits						
ow any		Tod. State	1 Yes 2 No						
Maryland 28a-f show d at once.	ctor	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?						
the Ma n or 28	Director	3102 Teal Lane 2071.							
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene I thant: If tien 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmaitie event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan If Yes, specify Cuban, Marital If Yes, specify	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.						
er deatl	Fun	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No s	pecify: Specify: White						
urs afte tural" amine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation	(Give kind of work done 16b. Kind of Business/Industry DNOT use retired)						
6 72 ho an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Homemaker	Own Home						
within siene.	dmo	17. Father's Name (First, Middle, Last)	Mother's Name (First, Middle, Maiden Surname)						
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	BeC	John Jepson	Dorothy Bent						
21; hould be nd Men is mar	2	110 Final Toro	nd Number or Rural Route Number, City or Town, State, Zip Code) race Silver Spring, MD 20901						
MC 2 sl and 2 sl salth ar em 27		20a Method of Disposition 20b. Place of Disposition (Name of cemer							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygier Important: If iten 27 is marked other than injury or other traumatic event, the Medica		1 Burial 2 Cremation 3 Removal from State crematory or other place)	c. 04/16/09 Baltimore, Maryland						
Ifim nit. Pa artmen sortani		21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part I. Enter the disease, or complications that used the lath. Do not enter the mode of dying, such as the late of the processing of the late of the late of the late of the late of the late.	Pacific Of Maryland, Inc.						
Ba pern Dep Imp		Thomas Gregor Jumas Day 299 Frederic	ck Road Baltimore Marvland 21228 ch as cardiac or respiratory arrest, shock, or hear Approximate Interval						
Physiciar 'Medica		failure. List only one cause on cach into	Between Onset and Death						
amine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
		Sequentially list conditions, b Inhalation of helium gas							
	iner	if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause							
- d	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed care been signed by the attending physician and care as the burial of the care of of the ca	7		vt						
60, ate be exe	Med	23c If was outcome of pregnancy	Vons						
Box 6876(g death certificate the attending phy	eician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 past 12 months? 7 Other (Specify)	Ectopic pregnancy Month Day Feat						
Box e death the atter	i o loi	1 Yes 2 ✓ No 9 Unknown 9 Unknown	ven in Part I. 23e. Did tobacco use contribute to the cause of death?						
P.O.	Detaction in	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	1 Yes 2 No 3 Probably 4 Unknown						
ords, P.O. w requires that as been signed to			24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of						
of Vital Records, g Physician: The law requir the this certificate has been st	sous 7	26 Place	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
tal Recision: The	r, page		of Death (Check only one)						
Vital hysician this cert	5 D	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other: Scene						
of \ing Phy	립	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	y at Work? 28d. Describe how injury occurred subject purposefully 18d. Describe how injury occurred purposefully						
ttendi death.	y the fi	Pending Investigation 4/14/09 11:00 pm 128e. Place of Injury - At home, farm, street, factory, office but							
Division Sepital or Attendi hours after death.	ed in b	Could not be determined (Specify) residence	uilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3102 Teal Lane Bowie, MD						
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi			to and place, and due to the cause(s) and manner as stated.						
To the P within 2- To the F	omplet	medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the time, date and place, and date to the casto(e)						
\$ 1 € 1 € 1 € 1 € 1 € 1 € 1 € 1 € 1 € 1	5		29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 15, 2009						
(10)		h) LrON IM							
W.		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201						
V.	√ Sta	32 Registrar's Signature							
Reg	gistr	rar AFR & I LOOD POPULATION							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1:00pm Ella Μ. Carter 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore Date of Birth (Month, Day, 6 13 Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2**X**)X 66 Director 214-40-8918 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Baltimore 1 X Yes 2 □ No Director N/A MD 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA Completed by Funeral 4319 Shamrock Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 🗖 O Specify 3€Widowed 4 □ Divorced Black "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Manor Care N/H C.N.A. 10th N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Lillie Hall ပ Brodie _Lyde 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2...
Department of Health a Important: If Item 27 is any Injury or other trau Anthony Carter-son 1 Copley Ct. Dover, DE 19904 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2009 Greenmount Crem. Baltimore 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Lady Baltimore, MD 21202 W 1101 E. North Avenue ware Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Enterobacter Bacteremia days /Medical Due to (or as a consequence of) Compartment Syndrome Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hemorrhage ician and burial-trans pe execu Due to (or as a consequence of): Box 68760, physician the burial Imonth Syndrome Nephrotic Physician/Medical The law requires that the death certificate 55 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy atter for u in the past 12 mont 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.0. the 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 2 No 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Director: After that in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 17, 2009 AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital Baltimore, MD 21218 Meegan C. Green, MD 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State

Registrar

			For State Registrar	State of Mar		ertificate of l			giene Reg. No. (2009	12608	
	Dhyaisi		1. Decedent's Name (First, Middle, Last)	<u>.</u>		-	2. Date of Dea	ath Day	Year	3. Time of Death	
	Physici /Medio		Day veonna Nevach Carter					04	16	2009	12:29 M	
	Examin	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore							4c. C	ounty of Death		
	Funeral		5. Social Security Number 6. Se		In yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 4/3/	h v Year)	9. Birthp Coun	lace (State or Foreign	
	Director			□M 2 X F	Yrs.	Months 14	Tiodis Willi.	4/3/	09	MD		
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or I	ocation.				10	Od. Inside City Limits	
Baltimore, Maryland 21215-0036	a-f sh	To Be Completed by Funeral Director	MD N/A		Bal	timore					1 XYes 2 □ No	
	th with the 23a or 28		10e. Street and Number 1811 Ashburton	st.		10f. Zip Code 2121 6	5		-	en of What Coun	try?	
	ours after dea' ral'', or items Examiner mu		11. Marital Status ★□ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 \(\text{Yes} \) 2 \(\text{XNo} \) If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 ^K No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		A. Race - Americ Black, White, e Afri Amer	can	
	within 72 ho plene. r than "natu the Medical		15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation fe completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire / A	pation during most of work d)	king		d of Business/Ind N/A	lustry	
	ld be filed fental Hyg ked other ic event,		17. Father's Name (First, Middle, Last) Tavon Carter		,		18. Mother's Nam Shanic	e (First, Middle, e N. W				
	nd 2 shou alth and N 27 is mar ir traumat		19a. Informant's Name/Relationship (7) Shanice N. Will			ling Address <i>(Street</i> 1 Ashbur					Code)	
	Pages 1 and nent of He and: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		20b. Place of Discemetery, cr Mt. Zi	oosition (Name of ematory or other pla	^{ce)} 4/24	Date / 09	20c. Loca Balt	ation - City or To	wn, State	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Scrvice Licens		74	22. Name and Addre 5126 Be	ess of Facility Ha Lair Rd,	ri P. Balt.,	Clos MD 2	e F.Sv 1206-5	s,PA 105	
	Physician	£ 1	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line.		nter the mode of dyl	1 570350				Approximate Interval Between Onset and Death	
	/Medical Examiner	Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions,	b. Triso		<i>y</i>						
Į.	recuted and -transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	consequence of):								
68760,	icate be executed physician and s the burial-transit			d								
Division of Vital Records, P.O. Box 68	the death certific y the attending p ched for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 l 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	☐ Ectopic pregnan	су		23	Bd. Date of delive Month	ery Day Year	
	ruires that t n signed by lid be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.							1 -		
	The law rectate has bee page 2 shou						<u>. </u>	24a. Was autop perfo 1 □Yes		24b. Were autoprior to condeath? 1 □ Yes	psy findings available inpletion of cause of	
	ician: certific ector,		25. Was case referred to medical examiner?	Hospital:		Oti	26. Place of Dea		- 1			
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	e Hospita n 24 hours e Funeral letely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To th withir To th comp		29b. Signature and title of certifier			_				29d. Date signed (Month, Day, Year)		
			flew she	A M.D		190	139		Apri	1,16,2	,2009	
			30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type	e, Print)	timos	MAN 212	01			
	Sta	te	31. Date filed (Month, Day, Year)	72. Registrar	s Signature	st, Bal	Ilmore,	1414 Z12	.01			
	Registr		APR 21 2009	Sender	3. Sa	Mark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 2100 M **Physician** /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Examiner N memoria If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year ocial Security Number 6. Sex 7. Age (In yrs. las **Funeral** Year) Months Days 1 □ M 2 F 709 ary Director Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, trained leaver in a mount to motified at 1 Kyes 2 No Director -Timor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Specia Elementary/Secondary,(0-12) College (1-4or 5 POLICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any injury or other traur melville lanish a 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State idaelstown. 4 ☐ Donation/ 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature uneral Servic Lic ma. Jar yer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease recondition resulting in death) Physician -HF exacerbation nicrow /Medical Due to (or as a consequence of): Examiner chronic OVI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Records, P.O. Box 68760, Division of Vital

be executed and burial-tran ed by the attending physician detached for use as the buria or Attending Physician: The law requires that the death certificate cate has been signed by page 2 should be detach certificate funeral director, this After t thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu Hospital

28a-f show

72 hours after death with

d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na

3altimore, Maryland 21215-0036

4 Homicide

(Check only

29a, Certifier

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

one) 29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

D.0

2 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Unwan 32. Registrar's Signat 31. Date filed (Month, Day, Year,

and manner stated.

State Registrar

Medical

the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Nui Woon Chung Chiu 7:00 PM 04 16/ 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Manor Nursing Home Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 06/19/1924 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 579-94-8430 1 □ M 2 👿 F 84 China Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 Ty Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 2095 Rock Rose Ave. 21211 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: Asian Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker Department of Health and Mental Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chi Chiu/son 3332 Hollow Ct., Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 4-22-2009 Fort Lincoln Cemetery 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee. 5555 Twin Knolls Rd., Columbia, MD 21045 23a. P. 11. Enter the dis 2.16, or confidentials that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List he not not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YORSTWO disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 31464 mD 42010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAW St Shite 308, BALTIMORE MD SHOPIIS A. HATUMI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:48 PM Apri **Physician** 2009 Chan Pauline /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bultimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 595.73.5296 1 □ M 2 XF)amaica Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the World Evaninat must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Battimore 1 Yes 2 No Randallstown Funeral Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Koad 2113 419iers Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Black Completed by 3 ₩Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant 12th Grade 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Monica Haye Harris Samuels ၣ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Randallstown MD 21133 Koad Kheron Chan Algiers 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Phesuile, MD Drud Ridge 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugin C. Ercene Funeral Services 21. Signature of Funeral Service License Jank Randallstown MD 21133 Koda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☒ No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 X Yes 2 □ No 2 □ No 1 X Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

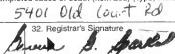
Baltimore, Maryland 21215-0036

P.O. Box 68760,%

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year) APR 2 1 2009

29b. Signature and title of certifier



Belchis, M.D. Pathwog ist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Randallstown Haryland

29d. Date signed (Month, Day, Year)

April 16 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g891 5-6-09 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04/16/2009 7:35 Ruth L. Conaway /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lorien Nursing Home Mount Airy If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MT) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. **Funeral** Year 1□ M 2 F Days Hours MD 214-12-0623 9-21-1913 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Experience must be retified at 1 ☐ Yes 2 No Director MD Carroll Woodbine 10g. Citizen of What Country? 10f. Zip Code 2 1 7 9 7 10e. Street and Number 5112 Woodbine Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXNo Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) her home Homemaker h and Mental Hygie 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Sellman Charles A Fleming . Pages 1 and 2 should be thent of Health and Ments tant: If item 27 is marked ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 Ridge Rd. Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print)
Raymond Conaway (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o HBurial 2 ☐ Cremation 3 ☐ Removal from State Ebenezer Cemetery 4/20/2009 Winfield, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Furrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury querifally list conditions Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last P.O. Box 68760, physician Physician/Medical the use as attending | IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Vear Day ned by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, signe be c Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed certificate 109 1 ☐ Yes 2 No 1 ☐ Yes 2 No r Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No after dea h 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide the Hospital completely filled e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29d. Date signed (Month. Dav. Year) 29b. Signaty

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 15 2669 APRIL **Physician** CATANZARO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HAVEN NURSING HOME CATONS VILLE
If Under 1 Year If Under 24 Hrs. 8. BALTIMORE 8. Date of Birth (Month, Day, y July 29 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Pennsylvania Hours Min. 220-14-5816 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or home 22 content any Injury or other trainment. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A 1 Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 443 Random Road 21229 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn F. Catanzaro, daughter-in-law 443 Random Road Baltimore, MD. 21229 20b. Place of Disposition (Name of Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State April 18, 2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 NATIONAL Address of Facility al Home, Inc. 1328 Sulphur Spring Ŕd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EBR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading times of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISORDER 1 Probably 4 Unknown Completed DISEASE 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 2 No 2/2/No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: Certification: To 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

Division or Vital Records, P.O. Box 68760. hours after deat uneral Director: within 24 hours a Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature) and title of certifier

29c. License number

29d. Date signed (Month. Dav. Year)

streem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTO MD 2/20 2835 SUITE 263

State Registrar

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MARY 6 CROOK PGUS 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner loward HUSPITAZ COUNTY GENERAL Corume, A toWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day April 9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 220-07-1887 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Director Catonsville 10e Street and Number 104 Shady Nook Ct. 10f. Zip Code 10g. Citizen of What Country? 21228 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 Is marked any injury or other traumatic ew once. William White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Anderson, daughter 104 Shady Nook Ct. Baltimore, MD. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National Cemetery 04-20-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21. Signature of Funeral Service Licensee 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician AWTE RUSP RATION 311445 /Medical Due to (or as a consequence of) Examiner 5 DAYS PARTUMON, A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a □Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ UNIVARY TRAZT INFECTION 2 No 3 Probably 4 Unknown Completed ENDONETRIAZ 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a, Was an autopsy performed? Yes 2 No certificate MALLUME CONGUSTIVE INSARIT 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending after death.

I Director: Af d in by the fur Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a

To the Funeral D Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

O. NYANDIM MO

D 36974

10724 LITTLE PATURENT PARKWAY

2509

21544

mo

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** D. Cade 04 15 2009 11:08a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 139 Edgewood Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 😾 F 78 Director 215-28-1948 28 30 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at Director 1 XYes 2 No Baltimore MD NA 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code Funeral 21229 139 Edgewood Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify þ Specify: Black 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12th_grade <u>Research Aide</u> Public Schools is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Mary Alston Joseph Price ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important; If item 27 is
any injury or other trau 404 Prairie court, Largo, Md 20774 Eric Cade-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Renoval from State <u>Garrison Forest Vet 4/23/09 Owings Mills, Md</u> 22. Name and Address of Facility
March Funeral Home West 21. Sign ure of Funeral Service License 4300 Wabash Ave, Baltimore, Md 21215 23a. Parti. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between o cardial Onset and Death **Physician** /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Causs (Disease or Inju that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No O. detached 9 ☐ Unknown 4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a Was an page 2 autopsy certificate 2**№** No 1 □ Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print), ar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

2 1 2009

09-03041 James Coberly Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

S Coberly		1- For State	e of Maryla	nd / Depar	rtment of tificate of	Health a Death	ind Me		Reg.	No			126
Physicia `वl Examir	ın/	Registrar 1. Decedent's Name (First, Middle,L. James	ast)	Co	berly			A	Date of Death Month D April 16, 200		ar	1059	
		4a. Facility Name (if not institution, g Harbor Hospital Center				b. City, Town, Baltimore			. Date of Birth(4c. County		place (Sta	ate or
Funeral Director		o. doora. dooran,	Sex XM 2 F	7. Age (In yrs. Ia 1	st birthday) . 9 Yrs.	If Under 1 Y	Pays Hou	urs Min.	Dec. 1		Foreign	4-3	D
v any		Usual Residence of Decedent 10a. State 10b. County	1 . 1		Town or Location	on							e City Limits
ith the Maryland s 23a or 28a-f show a notified at once.	Director	10e. Street and Number	Arundel	LIL		10f. Zip Cod				. Citizen of W	Vhat Count	ry?	
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urs after des tural", or i	þ		1 Yes ced If Yes, Give Yea or Dates:		16a. Deceden	Yes 2 X	upation (Gi			Specify 16b. Kind of I			
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permit. Departn Import	lάχ	21. Signature of Funeral Service L 23a. Part I. Enter the disease, or c			Se	rvices	,PA 1	2nd A	gleton ve.SW G	len Bu	ırnie	, MD	
Physician Medical xaminer		failure. List only one cause o Immediate Cause (Final disease	n each line. a. Metha	done in	toxicat		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Betwe	en Onset and Death
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Vital Reco ysician: The law his certificate has director, page 2 s	Bo Com	25. Was case referred to medical	Hospital:	1	2		Othe	Death (Check o	1 ✓ Yes only one) g Home 5	2 No Residence	1 • Y		2 No
Division of Vital Records, tal or Attending Physician: The law requir as after death. al Director: After this certificate has been selled in by the funeral director, page 2 should the fineral director, page 2 should the control of	-	1 V Yes 2 No	28a. Da (Mo	Inpatient 2 ste of Injury nth, Day, Year)	28b. Time o	f Injury 28	Sc. Injury at	Work?	28d. Describe				
Sicon dea	ortification.	2 Accident Invest 3 Suicide 6 X Coul	stigation 28e Pl	4/16/09 lace of Injury - At hon		i			28f. Location (or Town, Linthi	State) ()9	Babe	et Wa	te Number, City y
Divis To the Hospital or 4 within 24 hours after To the Funeral Director of	۷ ا	29a Certifier	nysician: To the b	best of my knowled	edge, death oc n and/or investi	curred at the t	ime, date a opinion, de	and place, and eath occurred a	due to the cau	se(s) and ma	nner as sta	ated.	
To T	Mag	29b. Signature and title of certifie	and manne	er stateu.			O.C.M.E			29d. Date April 17	signed (M	lonth, Day	y, Year)
Ø		30. Name and address of person Laron Locke MD. A	who completed o	ause of death (It	em 23a) r 111 Pe	nn Street,	Baltimo	re, MD 212	01				
Reg	Sta Sta	e 31. Date filed (Month, Day, Year)	9 2 32	Registrar's Sign	ature face	J							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** PEGGY JOANNE COOKUS April 13. 6:05 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Sparrows Point 40 Shore Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Mary Land 5. Social Security Number 8. Date of Birth (Month, Day, June 13, 7. Age (In vrs. last birthday) 6. Sex Funeral 1 □ M 2 🗓 F Months Days Hours Min. 218-44-2477 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County ral", or items 23a or 28a-f shov Examinar must be notified at Sparrows Point Maryland 1 4 1 Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with USA 40 Shore Road 21219 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2x No Specify: Completed by 3 N Widowed 4 ☐ Divorced White "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene Brooklyn Pest Control Co. Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William K. Neslein Eva Gertrude ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Dawn Sellars (Daughter) 1631 Shadyside Drive, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/17/09 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Fun al Service Licensee Kevin E Ecker 22. Name and Address of Facility McOully-Folyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YL years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ♠ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>S</u> 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2-□No 24a. Was an autopsy perfor certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28c. 28d. Describe how injury occurred 5 Pending investigation after death.

| Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the I 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JHBVMC Hel 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 18, 2009 Nicholas D'Apice 7:25 p M Anthony April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12300 Rosslare Ridge Rd., Unit 208 Timonium Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 ▼ M 2 □ F Months Days Hours 219-10-0258 July 2, 1926 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State **Funeral Director** 1 ☐Yes 2 No MD Baltimore Timonium 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 12300 Rosslare Ridge Rd., Unit 208 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Dives 2 No
If Yes, Give
Year or Dates: 44-46 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Engineer BGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) D'Apice Nicola Josephine ဥ Panico 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Unit 208^{Timonium}, MD 21093 Francis R. D'Apice-wife 12300 Rosslare Ridge Rd., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page: Department o Important: If i 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 4/21/09 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lineae William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 4R5 Immediate Cause (Final **Physician** 1/ETASTATA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Ulnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ director, page 2 should be 27 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 pilocal

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. _ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 04 Lamont Elder 2669 10:09 PM Jaiden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center Baltimore, Baltimore CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F Yrs. N/A Director 4/15/2009 42 Balt., Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Baltimore County Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21207 6 Garobe Court America 14. Race - American Indian, Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1√Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 No Specify: Black Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed what and Mental Hygier 7 Is marked other the N/AN/AN/Aor other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keon Ouenton Elder Patrice Angelene Spencer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 Is
any in]ury or other trau Mrs. Joyce L. Elder/grandmother 3911 Brenbrook Drive Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 20, 2009 Forest Hill, Maryland Chapel-- Rel Air : 2009 | Forest Hill, Maryland | 22. Name and Address of Facility | Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service Lice see 2325 York Road Timonium, Maryland 21093 Part 1 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Extreme frematurity **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hemorrhage Examiner Intraventricular 6 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 ☐ Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2**X** No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s has certificate 1☐ Yes 2☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient P 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: Atter Certification: Division Hospital or Attending 24 hours after death. Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature

Duck Elith (Merry Medical Cluster Buch Company) 32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ii yiai id /	•	tificate of l				2009	12	621
	Physicia		Decedent's Name (First, Middle, Las WILLIAM	st)		EADS			2. Date of Dea Month 04	nath Day	09 ^{Year}	3. Time of 7:50	
	Medic/ Examin		4a. Facility Name (If not institution, given JOSEPH RICHE				•	Location of Death	<u> </u>	4c. Co	ounty of Death		
	uneral irector		5. Social Security Number 6. S 212-42-6017	ex 7. Age	(In yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06-25-	1940	9. Birth Cou	place (State on try) MD	or Foreign
death with the Maryland	a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, To		ation					10d. Inside Ci	ity Limits
with the	t be not	I Director	10e. Street and Number 1320 N. FULT	ON AVENUE	· · ·		10f. Zip Code 212	17		10g. Citize	n of What Cou	ntry?	
U.So urs after death	do other than "natural", or items 23a or 28a-f show event, the Medical Evanime must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 M If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		. Race - Ameri Black, White, pecify:		
vithin 72 hours after	han "natur e Medical F	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1-4or 5	+)	(Give I life. D	OO NOT use retired	during most of work f)	sing		of Business/In	dustry	
filed	d other th	Be Col	6 17. Father's Name (First, Middle, Last)		P	ASSEM	BLY LINE	18. Mother's Nam		Maiden Su	rname)		
aryia should b	is marked other aumatic event,	잍	SAM EADS 19a. Informant's Name/Relationship (1:			AUDRE	ral Route Numbe	er, City or T		o Code)	
re, Mistand 2	Important: If Item 27 is marked any injury or other traumatic ev once.		MAMIE SHAW/COUSIN		20b. Place		20 N. FU	LTON AVE.	, BALTO		tion - City or To	own, State	
Saltimor permit, Pages	rtant: If i		1 Burial 2 Cremation 3	y)	MT. 2	ZION	CEM	04/23			IMORE,		TNC
perm Depart	lmpor any ir		21. Signature of Funeral Service Licer	. Mor	ton	22.		urens st					
	sician edical		23a. Parti. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	eal C	ance		ng, such as cardiac	4		ies	Approximat Interval Bet Onset and	tween
	miner		Sequentially list conditions	Due to (or to)									
58 / 50, tificate be executed	ig physician and as the burial-transit	ledical Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d						-			
I RECORDS, P.O. BOX 60 The law requires that the death certific	To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у		23	d. Date of deliv		Year
dS, F	signed b		Part II. Other significant conditions of	ontributing to death bu	- K	-	derlying cause giv	en in Part I.			contribute to		
Kecords, he law requires t	e has been ige 2 shoul	Completed by								rmed?	death?	ompletion of o	available cause of
OT VITAI Physician: T	certificat ector, pa	Be Co	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea	1 ☐ Yes th (Check only o		1 □ Yes	2 11No	
Phys	r: After this one funeral dir	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 2 ER/ ry 28t v, Year)	Outpatien Time of Injury	28c. Injur Wor	v at	ome 5 ☐ Residence 1				pe
DIVIS	Il Directo ed in by th	Sertific	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, c. (Specify)	farm, stre	eet, factory, office		28f. Location (8 City or Tov		Number or Rur	al Route Nun	nber,
DIVISION To the Hospital or Attending within 24 hours after death.	e Funera	Medical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner sta	f examination	dge, death and/or inv	n occurred at the till vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s	s)
To th	To th comp	Me	29b. Signature and title of certifier	1			29c. Licens				signed (Month,		
	2 1		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, I	Print)	1476 12 416, BB				U	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pgistr	ar's Signature		1120 07 00		1.11.00	11.0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day / & Month Year **Physician** April 0/ 00 Virginia Evans Dolores 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BUCNIC Glen ANNE BAltimore Washington Medical Giter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 08-10-1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months. Days Hours 1 □ M 2 🛛 F MD 215-28-8412 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinational be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Pasadena 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? 8133 Mountain View Circle 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🎢 No Specify. Specify: White 至 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Steel Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Uttenreither Henry Naumann ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Constance Burnham /Daughter 669 E. Clement Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iten
any Injury or ott
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 04-23-2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Small Physician ION (411 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? icate has t certificate I 2 No 1 ☐ Yes 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Mnpatient . 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours atter death.

To the Funeral Director: A completely filled in by the fu To the

Frans

MO tenr

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BAltimor WAShington Medical Center 32. Registrar's Signature

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 13in 06: 10 PM **Physician** Howard Edward Easton APRIL 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE HOSPITAL St- AGNES 8. Date of Birth (Month, Day, Ye. Feb. 10, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday))^{Year)}1932 **Funeral** Months Days Hours Maryland Yrs. 216-28-6200 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experiment must be not lined at 1 □Yes 2 ▼No Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 United States 1557 Sulphur Spring Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after on and Mental Hyglene.

is marked other than "natural", or iten 1 □ Never Married 2 □ Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Carolina Freight 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Bloom Hugh Easton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5226 Arbutus Avenue, Arbutus, MD 21227 1 and 2 s Health ar Brenda Easton - Daughter permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of Medical Place) 20c. Location - City or Town, State Method of Disposition 1 Naurial 2 ☐ Cremation 3 ☐ Removal from State 4-17-2009 4 Danation Elkridge, Maryland 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA PSEUDOMONAS Monms Physician /Medical Due to (or as a consequence of): months Examiner THROMBOCYTOPENIA HEPARIN INDUCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PULMONARY COEMA is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, pulmonony Chronic Obstructive Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D Mallie. A P22257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) APR 2 1 2009

MALLIKA ANGITIPALLI

ST. AGNCS HOSPITAL, 900 S CATON AVENUE, BALTIMORE 32. Registrar's Signature

HOWARD.

40-21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Woodrow W. Ewen ам April 1:35 2009 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Towson Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Davs Hours 1**X** M 2□ F 500-14-5702 Director 88 Chillicothe, MO 01/07/1921 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5420 Whitlock Road 21229 United States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 □Yes 2 ☑No Specify: Specify: White ð 3 ₩ Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Timekeeper Electronic/Manufacturing marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 is marked o Dudley B. Ewen Virgie Rickett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Mr. David Ewen (Son) 65 Shirley Lane, Littlestown, PA 17340 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Tremation 3 Removal from State Bayview Crematory 04/21/2009 | Baltimore, Maryland 1. Signature of Fulleral Service Lice Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final PROSTATE CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**X** No Physician: The certificate 2 🗆 No 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one)

Physician /Medical Examiner

2121

Maryland

Baltimore,

Box 68760.

Vital Records, P.O.

ð

Division or Attending

WOODROW EWEN

2009

Certification: To

Medical

Other: $_4\,\square$ Nursing Home $_5\,\square$ Residence $_6\,\blacksquare$ Other (Specify) **HOSPICE** 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner.

Nurse Practitioner. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year, State

APR 2 1 2009



Registrar

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124 hours after death.

Be Funeral Director: A pletely filled in by the fu

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death.

After th funeral

		1 - For Amend Item	State of Marylan n 8 per fh, g898	d / Departmen ,12/22/09dl <i>Certificat</i>	t of Health an ib e of Death	d Mental Hy	giene Reg. No. 2	009	12625
Physic	ian	1. Decedent's Name (First, Middle, La		1-		2. Date of De Month	eath Day	Year	3. Time of Death
/Med		Helen	N. FOW!		. 500.071	04	13	2009	11:40 M
Exami	ner	4a. Facility Name (If not institution, gi Good Samari H			Town, or Location of D Himore	eath	4c. Co	unty of Death	
Funeral			Sex 7. Age (In yrs.	last birthday) If Under	1 Year If Under 24			9. Birthpl	lace (State or Foreign
Director		224-32-1026 Usual Residence of Decedent	1□M 2) 20 8	Yrs.		10/31/	1919	5.0	AROLINA
yland how		10a. State 10b. County	10c. Cit	y, Town or Location		 		10	Od. Inside City Limits
ne Mai 8a-f s	ctol	Md.	B	AL TO.					1 Yes 2 No
with the a or 2	Ö	10e. Street and Number	Pentland R.	10f. Zip	11234		-	of What Count	ry?
death ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was Deced	dent of Hispanic Origin	? (Specify Yes or No	o- 14.	Race - America	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination continuation continuation of the Medical Examination of the Medical Examinatio	þ	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	1 ☐ Yes	cify Cuban, Mexican, P	uerto Rican, etc.)		Black, White, e	, , ,
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Maryland d 2 should be file th and Mental H; i'i s marked oth traumatic event		19a. Informant's Name/Relationship	6. 21.	19b. Mailing Address	(Street and Number of	or Rural Route Numb	per, City or To	own, State, Zip Bol. Ta	Code)
or other tr		20a. Method of Disposition		lace of Disposition (Naremetery, crematory or o	thar alsool 1	Date		ion - City or Tov	
altimore, rmit, Pages 1 ar ppartment of Her portant: If item y Injury or othe		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec.	☐ Removal from State ☐	ROWNSU	·//e	4-17-09	CRO	WNSU	://e Md
Baltimo permit. Pag Department Important: Pag any Injury o		21. Signature of Funeral Service Lice		22. Name ar	d Address of Facility	Wesley!	MAU	SSY-	lle Md. E.H. Rol TO M
		23a. Part 1. Enter the disease, or cor shock, or heart failure List only	nplications that caused the death	n. Do not enter the mod	le of dying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
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/Medical Examiner		resulting in dealiny	Due to (or as a consequ	uence of): Cailure					
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ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
58760, ficate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
_ ± ⊙ α	Medical		0						
P.O. Box 6i nat the death certific d by the attending p etached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3 🗆 Ectopic p			23d	. Date of delive Month	ery Day Year
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s that i	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying c	ause given in Part I.	23e. Did	tobacco use	contribute to the	e cause of death?
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ecc faw r las be s 2 sh	Completed					24a. Was	an 2	4b. Were autop	osy findings available npletion of cause of
al R						1 □ Yes		death? 1 ☐ Yes	2 🗹 No
Vit /sicial s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient 3 D	T	Death (Check only ng Home 5 ☐ Res		Other (Specific	d
ng Phy ter thi	n:	27. Manner of Death	28a. Date of Injury (Month, Day, Year)		28c. Injury at Work?	28d. Describe			/
SiOI tendir eath. for: Ai	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not I	on	М	1 ☐ Yes 2 ☐ No				
Division of Vital Records, tal or Attending Physician: The law requires the safter death. The law rector: After this certificate has been signe led in by the funeral director, page 2 should be desired.	Certification: To	4 ☐ Homicide determined	building, etc. (Specif			City or To	wn, State)		I Route Number,
Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	Medical	29a. Certifier 1	'hysician: To the best of my kno iminer: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and p n, in my opinion, death	place, and due to the occurred at the time	e cause(s) an , date and pla	nd manner as st ace, and due to	ated. the cause(s)
To t To th	Ž	29b. Signature and title of certifier	410		c. License number			igned (Month, L	
		> Hellef	_		es -000			- 13-	2003
4 V		30. Name and address of person who Natallia Maroz,	5601 LOCK P.	aven BLVd	, Baltin	rore, M.	D,	11239	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa						
DHMH 17 Rev 1/	_	APR 21 20	09 Senus 1	9. parket					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 890 4-21-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Michelle E. Kalendekcrup

Reg. No.20 For State Registra Э 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Fuch 5 4:15 AM 2009 Glenn 1.7 DH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Genesis multimedical Center 7700 York Rd. | TOWSON, MD 21 207
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, | NOV | 9. Birthplaca (State or Foreigr County X y 1 and 7. Age (In yrs. last birthday) Social Security Number **Funeral** 212-10-2201 Usual Residence of Decedent 10 M 2□ F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other treumatic event, the Medical Examiner must be notified at MARYLAND BALTIMORE 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen ol What Country? 10e. Street and Number 21009 3208 A or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 W No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Heelih and Mental Hygiene. important: if Item 27 is marked other than "nt eny injury or other treumatic event, the Medil once. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 18-2009 FOR 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility \$80 HARFORD RI

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 22. Name and Address of Facility \$850 HARFORD RD PARKVIUG CHAPELY GREMATION SERVICE Immediate Cause (Final disease or condition resulting in death) **Physician** Amyloidosis with multiorgan Involvement ~ 1 year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol): Physician/Medical Examiner the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Nephrotic Sindrome **Be Completed** 24b. Were autopsy lindings available prior to completion of cause of death? Metabolic Acidos 24a. Was an autopsy performed? Steroid myopathy 2 🗆 No 1 TYes 1 ☐ Yes 2 PNo i or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No Hospital: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 1 ⊠Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Rhysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funeral D 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number michille & Halender CRUP R097104

Registrar DHMH 17 Rev 1/2001

State

Rd, Towson MD 21204

7700 York

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

enter

Genesis Multimedical

APR 2 1 2009

31. Date liled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #23e Per Phy G890 4/28/09 JH
State of Maryland / Department of Health and Mental Hygiene
1- For State Amend 9, 10d, per FH g890 4/28/09 TT
Certificate of Death

Reg. No. 2009 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 21.20 M 04 16 2008 **GARNER** SADIE J. PANKEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 6100 EVERALL AVENUE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Country) Virginia **Funeral** Days Hours 1 □ M 2 F Months 70 September 11 1934 217-34-6364 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Modical Example in a partial of a 1X Yes 2 ☐ No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6100 EVERALL AVENUE 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 □Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if Item 27 is marked other that any Injury or other traumatic event, Item 2006. 12 CASHIER WALMART 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SADIE DANIELS ဥ HUBERT PANKEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4630 CHATFORD AVE. BALTIMORE, MD TRINA GARNER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4-24-2009 APPOMATTOX, VA 4 ☐ Donation 5 ☐ Other (Specify) SPRINGFIELD BAPT.CEM. 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shieck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 14 months **Physician** ADENOCARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ + S ∨ 2 No 3 Probably 4 No nknown Completed Discuse 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Decine 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hours a' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20062966 relpe. MD APRIL 2009

Hospital or Attending Physician: To the within 2 To the I

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Maryland 21215-0036

3altimore.

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Mp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S Greene

Teter

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21201

MD

BALTMURE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Gamble 7:00pm 2009 Alfred George 04 8. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Communicare Health Services Baltimore Year) 36 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 01 05 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Hours Min. Days **X**□M 2□F MD 219-28-2089 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a, State 1X Yes 2 No Baltimore Director MD NA 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21217 U.S.A. Funeral 610 Gold Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2√☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mail Clerk Post Office 8th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche Gross George R. Gamble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 610 Gold Street, Baltimore, Md 21217 Michelle Dukes-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 4/20/09 Baltimore, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. 21215 Baltimore, Md Immediate Cause (Final - WNG Capcinoma y-ear disease or condition resulting in death) Due to (or as a consequence of): DISPUSE 41 Meterstatic Se uentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of). 10413 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗖 Mo 25. Was case referred to medical 26. Place of Death (Check only one)

death certificate be executed and Box 68760. attending physician P.0. Division of Vital Records, this ō

burial-tran Physician/Medical the ed by the a detached f cate has been signed by page 2 should be detach þ Completed director, Be Certification: To funeral hours after death. Ineral Director; A þ

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examination ust by multified at

th and Mental Hygien 7 is marked other the

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral I

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1∐Yes 2∐No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

D30494

Cataminite mis

4/20/09

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLUYE 302 choice loue

Maidey > ic 32. Registrar's Signature 2009

K DESHIM

09-03057 Do

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

orothy Glorioso		St - For State legistrar	ate of Maryland /		tment of ificate of		d Menta		eg. No.	20	09 1262
Physician Medical Examine	1/	1. Decedent's Name (First, Middl						2. Date of Dea Month April 16, 2		Year	3. Time of Death 2001 hrs
neulcai Examin		Dorothy J. 4a. Facility Name (if not institution				4b. City, Town, or	Location of			County of Deat	
		Johns Hopkins Bayvie				Baltimore	a léllada.	OALIES IO Date of Bu	th/A/A/(D)	N/	A rthplace (State or Foreign
Funeral Director		5. Social Security Number 219-28-5455	6. Sex 7. Age	(In yrs. las 76	Yrs	Months Day		Min. 08-22-		Co	aryland
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Locat	ion					10d. Inside City Limits
land f show	١		1/A		_	Balti	more				1 X Yes 2 No
- 2 = 1	2	10e. Street and Number 5810 Judith Wa	ay			10f. Zip Code	2120	6			S.A
death with or items 2	Funeral			Ever in U.S. X No	If Y	es, specify Cuba	n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		White, etc.	rican Indian, Black, White
s after	≥ -	3 X Widowed 4 Div	vorced If Yes, Give Year or Dates: ecify only highest grade com	pleted)	16a. Deceder	Yes 2 X No	tion (Give ki	nd of work done		Specify: nd of Business	
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vithin giene.	[17. Father's Name (First, Middle	a Last)		dar illeri	IL WOLKE		Name (First, Middle,			Thursty
21215-0036 ould be filed within 7 Mental Hygiene. Is marked other than ic event, the Medica	Be C	Frank E. Rippl						y H. Bull			
Sh Sh I is	≗∫	19a. informant's Name/Relations Mrs. Rosa Papa			4	g Address (Stre adbridge		oer or Rural Route Nu Baltin			te, Zip Code) and 21237
e, M I and 2 Health item 2	- 1	20a. Method of Disposition			1	sition (Name of ce		Date		ocation - City o	
C 00 F 1		1 X Burial 2 Cremation 4 Opnation 5 Other S	Specify:	oak	Lawn	Cemetery	/	4-21-2009			e, Maryland
Baltir permit. 1 Departm Imports Injury or		21. Ighture of Fundal Service	e Licensee			Name and Addres				Harford more	d Road MD 21214
Physician	+	23a. Part I. Enter the disease, or failure. List only one cause	or complications that caused	the death. I	Do not enter t	the mode of dying	, such as ca				Approximate Interval Between Onset and
/Medical xaminer	ı	Immediate Cause (Final disease or condition resulting in death)	e a. Atherosclerotic			sease					Death
		Sequentially list conditions,	Due to (or as a conse								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of)							A
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760, ficate be g physici the buri	₩e	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcor	ne of pregn		etal death 3	Ectonic	pregnancy		. Date of delive	ery Day Year
Box 68761 certificate the attending phy defor use as the be	sician/M	past 12 months?	4 Pregnant at	time of dea		etal death 3 other (Specify)	Lotopic	pregnancy			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
D. Bo the dea by the a	Phys	1 Yes 2 No 9 Ur Part II. Other significant condi	itions contributing to deat	h but not re:	sulting in the	underlying cause	given in Par	rt I. 23e. Did	tobacco u	use contribute	to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death and this certificate has been signed by led in by the funeral director, page 2 should be detach.	ব								es 2	No 3 Pr	obably 4 Unknown
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Divigital or / Iral or / Iral or / Iral Dire	Certification:		uld not be termined (Specify)	ijury - At no	ime, iarm, sire	eet, factory, office	bullarily, etc	or Town,		na ramber or i	Agran Acote Namber, only
	Medical C	29a. Certifier 1 Certifying I	Physician: To the best of maniner:On the basis of examiner stated.	y knowledg mination an	e, death occurred/or investiga	urred at the time, ation, in my opini	date and pla	ice, and due to the ca curred at the time, dat	use(s) an e and pla	d manner as st ce, and due to	ated. the cause(s)
F 3 F 8	Me	29b. Signature and title of certif					nse number		-1 -		Month, Day, Year)
		Aflin Bu	anell, MA.	dooth /ita-	220)	0.0	C.M.E.		Apri	1 17, 2009	
		30. Name and address of perso Melissa Brassell, MD	Assistant Medica	I Examin	ner 111	Penn Street,	Baltimore	e, MD 21201			
Sta Registi	ite rar	31. Date filed (Month, Day, Year APR 2 1 2	2009 Senera	ar's Signatur	bare	les .					
DHMH 17 Rev 1/20	01	00015	,	~	ORIGINA	AL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APril **Physician** Darlington 18. 2009 6:00 A. Joseph Hoopes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2001 Waverly Drive Bel Air Harford 8. Date of Birth (Month, Day,)
Nov. 28, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 103 1905 Maryland 215-36-8079 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examination to rediffical at 1 ☐ Yes 200 No Director Harford Maryland Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21015 2001 Waverly Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2√No Specify. Specify: White 2 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) n and Mental Hygiene. Elementary/Secondary (0-12) Farmer Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Hoopes ဂ <u>Annie Jean Watson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2234 Gibson Rd. Forest Hill, MD 21050 Paul Hoopes / Son Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of Cometant Crematory of other place)

Evans Funeral Chapel April 20. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 Forest Hill, Maryland Bel Air 21. Signature of Funeral Service Licensee Evansa Fuller a factor apel & Cremation Services - Bel Air dear 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RERIDSCHERDTIC CARDIOVASCUL Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 No. page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria After t n 24 hours after death. • Funeral Director: A oletely filled in by the fu completely

the

death with

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Certification: To Medical

2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

ompleted cause of death (Item 23a) (Type, Print)

and manner stated.

INORTH

State Registrar 32. Registrar's Signature

within 24

			State of Maryland / Department of Health and N State Certificate of Death		giene Reg. No. 200	9 12631
			Decedent's Name (First, Middle, Lest)	2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		MATHILDA HARPER	Month APRIL	Day Year 15, 2009	1850 ™
Who are	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	ath
			PRINCE GEORGE'S COMMUNITY HOSPITAL CHEVERLY 5 Social Security Number 16 Sex 17 Age (In yes last hirthday) If Under 1 Year If Under 24 Hrs.	0 Data of Bird		GEORGE Sirthplace (State or Foreign
	Funeral		Months Days Hours Min.	8. Date of Birt (Month, Da	y, Year) (rtinpiace (State of Foreign Country)
	Director		201-28-2846 81 Usual Residence of Decedent	JUNE 4,	1927 PA	
	yland how	,	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	Director	MD PRINCE GEORGE'S UPPER MARLBORO			1X Yes 2 □ No
	ith th	Dir.	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	Country?
	sath v	eral	13005 CLOVERLY DRIVE 20774 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No	USA 14. Race - An	nerican Indian
36	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Eventiner rust be notified at once.	by Funeral	Armed Forces? 1 Never Married 2 Married If Yes, Specify Cuban, Mexican, Puerto If Yes, Give It Yes, Specify Cuban, Mexican, Puerto If Yes, Give It Yes, Specify:	Rican, etc.)	Specific -	
21215-0036	tural'		3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	
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Maryland	d 2 sh Ith and IT is r traur		19a. Informant's Name/Relationship (Type. Print) MATHILDA ALEXANDER / DAUGHTER 845 SADDLEBACK TRAIL I		SAPEAKE, VA	
ē,	f Heal			Date	20c. Location - City of	
E 0	Page: nent o nt: If i		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Restland Memorial Park: 04-2	5-2009	MONROEVIL	LE. PA
altimore,	rmit, partn porta y Inju		21. Sign on of Funeral Service Licensee 22. Name and Address of Facility MAI	RSHALL'S	FUNERAL I	HOME OF MD
<u> </u>	89 = 89		DEREK E. SLOCUM 4308 SUITLAND RD			0746
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY FAILURE			
7	/Medical Examiner		Due to (or as a consequence of): CEREBRAL OEDEMA			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
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of Vital Records,	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 1 ☒ Yes 2 ☒ No Contact the series of Deat the			
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ion	Attending ir death, ector: Afte by the fune	atio	1 🔯 Natural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division	l or Atte after dea Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or To	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and manner stated.			
	To the within 2 To the Completed	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	F>F0		D21883		APRIL 16,	2009
			30. Name 171 - 11 ss of erson the complified cause of death (Item 2 a) (Type, Print)		-	7.12 (1.13 (W.)
	<u>1</u>		HEMA P. YADLA MD 9470 ANNAPOLIS RD STE 315 LANHAM, M	MD 2070	06	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 1035 AM 2009 Robert Leon Hanley 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** more N/A If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 ☐ F **Funeral** Year) Hours Days Months Yrs 81 1927 193-14-8539 Jun. Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Madical Experiment must be cellified at once. 1 ☐ Yes 2 🛣 No Director Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7691 Rowanberry Drive, # 103 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 194

If Yes, Give
Year or Dates: 196 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1944-1 □Yes 2 No Specify. White Specify: δ 3 Widowed 4 Divorced 1965 Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government <u>Graphics Artist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard M. Hanley Minnie Ruth ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7691 Rowanberry Dr., #103, Elkridge, MD 21075 Alma Hanley - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition MD (Veterans Cemetery 4-21-2009) 1XI Burial ∠. 4 □ Donation Burial 2 Cremation 3 Removal from State Crownsville, Maryland 5 ☐ Other (Specify) @ Crownsville 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi

29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

within 24 hours a State Registrar

Immediate Cause (Final disease or condition	Respiratory falivre	2 Month
resulting in death)	Die to (as for nsequence) (): D: FFUSE Dreumon: 1:5	1 month
School list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Distrise encerhaloputhy	2 monte
resulting in death) Last	Due to (A) a consequence of):	1 month
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	industry to death but not recording in the analyting eaches given in the analyting	use contribute to the cause of death?
	24a. Was an autopsy performed? 1 ∐ Yes 2 ☑ N	
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Mork? 1 □ Yes 2 □ No 28d. Describe how inju	iry occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a City or Town, State	nd Number or Rural Route Number, re)
29a. Certifier (Check only 2 Medical Exami	Lician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date ar	s) and manner as stated.

P23625 01/16/ lt:mo/e, MD, 2122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1,per MD, #16b & 19a,perFH g890 4/28/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Melvin E. Hanzook, Jr. 2. Date of Death 3. Time of Death Day Month Year 11:45 AM **Physician** HANZOOK APRIL 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 19,1958 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 217-48-2665 50 **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examirer must be notified at MD Baltimore Rosedale 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 USA 1322 Roxboro Road Funeral Pages 1 and 2 should be filed within 72 hours after death neath of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23 ant: If item 27 is marked other than "natural", or other traumatic event, Item Redical Examination or uny or other traumatic event, Item Redical Examinations. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. ģ If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Inc. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Regional Mgt Ink 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin E. Hanzook Sr. Reta Goldsmith ပ္ 19a Michelle Name/Relationship (Type. Print)
- Michelle Hanzook /wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Roxboro Road Balto. MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2XX remation 3 ☐ Removal from State Bayview Crematory 4/24/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SYNDROME **Physician** HEPATORENAL 10 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PANCREATIC CANCER UNKNOWN METASTATIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Day 5 Other (specify) by the 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I lirector, page 2 s autopsy performed? 1 ☐ Yes 2 🗖 No 1 ☐Yes 2 ☐No this certific ral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 🔀 Natural death. 1 ☐ Yes 2 ☐ No after death

Director: A

d in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Maccico RESOUC 20 2009 MD APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

17

Registrar

State 31. Date filed (Month, Day, Year)

ADEKUNLE OBISESAN, MD.

32. Registrar's Signature

3001 SOUTH HANDVER STREET, BALTIMORE, MD 21225

Kathleen Elizabeth Hall

2009 12634

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

		- For State Registrar					Certific	cate of	Deatn_					leg. No.		Тат	ima of Dooth
Physici edical Exami	an/	Decedent's Nam		lle,Last) nleen		Eliz	abet	h	Hall				Date of Dea Month April 18, 2	Day 2009	Year	C	ime of Death 0626 hrs
		4a. Facility Name (i	if not instituti	on, give st	treet and nu			41	o. City, Tow Belair	vn, or Lo	ocation of	Death			c. County of Dea Harford	ath	
Funeral		5. Social Security N		6. Sex		7. Age (In	yrs. last b	oirthday)	If Under	_	If Under		8. Date of B	irth(MM	/DD/YYYY) 9. E Fore	eign	
Director		213-60-57	729	1M	2 X F		53	Yrs.	Months	Days	Hours	Min.	June 3	30,	1955	Country	Maryland
λ :		Usual Residence o				1100	City. Toy	wn or Locatio	on							100	I. Inside City Limits
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Maryland 28a-f show any d at once.	Director	PA 10e. Street and Nu	<u> </u>	LK				.r vrrr	10f. Zip C	ode				10g. Ci	tizen of What C	ountry?	
the Ma ia or 2	ä	7340 T	Woodbi	ne Ro	oad				17.	302					U.S.A		Indian Block
r death with the Maryland or items 23a or 28a-f shor must be notified at once	Funeral	11. Marital Status	ied 2 X		12. Was De Armed F			13. Was	Decedent es, specify	of Hisp Cuban,	anic Origi Mexican,	in? (Spe Puerto F	cify Yes or N Rican, etc.)	10-	White, etc		indian, black,
ter dear ", or it	直	3 Widowed			1 Yes Yes, Give Ye	2 X	No	1	Yes 2	X No	specify:				Specify:		ite
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-003 d withing spiene.	om	12 17. Father's Name	(First, Middl	e, Last)				Clar	IIIS EX	1.	8.Mother	's Name ((First, Middle	, Maide	n Surname)	خللة	LLOIL -
215 be file ntal Hy rked o	Be		Bern			O'Con	nor				111	J	orain	e_	Burr City or Town, St		n Code)
D 21 should and Me 7 is ma	은	19a. Informant's N				Husbai			Wood						PA 1730		1
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		William 20a. Method of Di	sposition				20b. Pla	ce of Dispos matory or oth	ition (Name	e of cem	etery,		Date	200	c. Location - City	or Tov	vn, State
nore		1 X Burial 2			Removal	from State		cwood		erv		4-2	3-2009	В	al <u>timor</u> e	e	<u>Maryland</u>
altir mit. P spartme iportai		21. Stanaturo di	nera Cervi	e License	ее		1011	22. N	lame and A	Address			uck To	wso	n Funera	al l	Home, Inc.
_		23a. Part I. Enter	the disease.	or compli	tations that	caused the	death. D	o not enter t	1050 he mode of	Yor	K KO	ad ardiac or	respiratory	n, I	Maryland shock, or heart		Approximate Interval
Physiciar Medica		fallure. List o	only one caus	se on eac	h line. Iultiple Ir												Between Onset and Death
xamine		Immediate Cause or condition resul		-		a consequ	ence of):										
	Ē	Sequentially list of if any, leading to		b	ue to (or as	a consequ	ence of):										<u> </u>
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Box 687 ne death certific the attending	Physicia	past 12 mont	hs? No 9 ✔	Inknown	1 =	gnant at tin	ne of deat	h 5 0	ther (Spec	cify)				- 1			
). Bc the dear	Phy	Part II. Other sig				known g to death b	ut not res	ulting in the	underlying	cause g	given in P	art I.					e cause of death?
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ords, w requir													24a. W	as an utopsy erforme	prio	r to cor	psy findings available apletion of cause of
Reco	Completed											_	1 🗸 Y			Yes	2 No
of Vital Records, ling Physician: The law requir	Be C		ferred to med		ospital:	Inpatient	2 -	R/Outpatier			of Death Other		only one) ng Home 5	Res	sidence 6	Other:	
of Vi		27 Manner of De	2 No			ate of Injury		28b. Time of			iry at Wo		28d. Descr		injury occurred		
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Division spital or Attendit hours after death.	Certification:	3 Suicide	6 🗌 0	Could not betermined	28e. P			ne, farm, str / Highwa		, office I	building,	etc.	I or Toy	n. State	et and Number e) I Road, , Md.	or Rura	Route Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director.				g Physici		h - at at may 1	len outload de	o death occ	urred at the	e time, d	ate and p	olace, and	d due to the at the time, o	cause(s	and manner as diplace, and due	s stated to the	i. cause(s)
To the Ho within 24 To the Fu	Medical	29b. Signature a			and manne	er stated.					se numbe				9d. Date signed		
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/Medic	_	4a. Facility Name (If not institution, The Johns Hopkins	Hospital		Baltimore				unty of Death	ace (State or Foreig	70
Funeral Director		5. Social Security Number 220–74–5198 Usual Residence of Decedent	6. Sex 1 X M 2 □ F 7.	Age (In yrs. last birthday 50 Yrs.	Months Days	Hours Min.		y, Year) 1958	Mary]	y)	
land		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limit	
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h the	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen	of What Countr	y?	
th wit 23a c		2730 East Bidd	le Street			21213		U.S.			
ite, INTALYIGITU ZIZIO-UOSO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 2 Divorced	If Yes, Give Year or Date	X No s: 16a. Dec	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No edent's Usual Occur	Specify:		Sp	Race - America Black, White, et ecify: Blac of Business/Ind	tc. ck 	
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2 should and Men is marker aumatic		19a. Informant's Name/Relations			ling Address (Street						
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Dail. permit. Departi Importa any Inji		21. Signature of Funeral Service	icensee		22. Name and Addr					-	
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Physician // // // // // // // // // // // // //	84	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on eacl	ised the death. Do not enh line. Solom Orath ras a consequence of):		ing, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
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requisionalist	Completed			•			24a. Was	an 2	24b. Were autor	osy findings availat	ble
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Phys this c	<u>ا</u>	1 X Yes 2 □ No 27. Manner of Death	28a. Date of		of 28c, Inju	ury at	28d. Describe				
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affer affer din b	erti	4 Homicide	building	g, etc. (Specify)			City of 10	wn, State)			
To the Hospital or Attending Physician: The Is within E4 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page.	edical C	29a. Certifier 1 Certifyir (check only one) 1 Medical	ng Physician: To the be Examiner: On the bas and manne	est of my knowledge, de sis of examination and/or er stated.	ath occurred at the tinvestigation, in my	time, date and place opinion, death oc	ce, and due to the courred at the time	e cause(s) ar e, date and p	nd manner as si lace, and due to	ated. the cause(s)	
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- 5 = 0		1/	physicia	an	De	66303		AD	ri12020	09	
		30. Name and address of person							1	-	
		Johnathan	Sheele		,	600	North W	olfe St,	Baltimor	e, MD, 212	87
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DHMH 17 Rev 1/2	2001		July	1							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year APRIL 5.40 **Physician** 2009 **JOHNSON** OSCAR EZEKIEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE FUTURECARE-SANDTOWN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**XX**M 2□ F 12/04/1920 VA Director 88 214-26-4238 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantion must be notified at 1 XYes 2 □ No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21217 1510 N. STRICKER STREET Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force ∐Yes 2**X** No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 Widowed 4 □ Divorced BLACK Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) CEMENT MASON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN WILLIAM JOHNSON PEARL DABNEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DEBORAH BRYANT/DAUGHTER 4400 OLD COURT RD. APT. L, BALTO., MD 21208 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 4/24/09 MT. ZION BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 21217 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOVASCULAR YEARS THEROSCLEROUC resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a some equation of): Examine and burial-tra Due to (or as a consequence of): the attending physiciar death certificate be Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death Pregnant at time of death 3 - Ectopic pregnancy Month Year signed by the atte Day 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 2 🗆 No 1 ☐ Yes 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 200 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

P.O. Box 68760 Division of Vital Records, Hospital or Attending P 24 hours after death. Funeral Director: After t

completely filled in by the funeral To the Hospital within 24 hours a To the Funeral D

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 \tomicide

29a, Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course of

29d. Date signed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. EUTAWST. # 407, MD 21201 Kumar

32. Registrar's Signature

asanthalaums

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day i 8 Month **Physician** 10,45A M toric W9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ndall 6 la mas o If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day 9. Birthplace (State or Foreign Country) Security Number 7. Age (In vrs last birthday) **Funeral** 1 M 2 □ F Months 8 1ano Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner numb be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Zes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ Yo \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kind of Busin 15. Decedent's Education (Specify only highest grade completed) than " Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than College (1-4or 5+) or other traumatic event, 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Maiden Surname Be ျှ 19a. Informant's Name/Relationship (Type, Print. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.9
Department of Health as Important; If Item 27 is any Injury or other trauonce. 10 mon m 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Rurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vei 21. Signature of Loneral Service Licensee 22. Name and Address of 23a. Part venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate value (Final disease or or dition resulting in death)

a. A Commence of the disease of the disease or difference Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Exami The law requires that the death certificate be execute as the burial-trans MIC and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical 121110N IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a d be detached fo 5 Other (specify) P.O. E ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 图 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOOG1420

State Registrar

DHMH 17 Rev 1/2001

NIBERTY HEIGHT NE.

BALTIMORE, MD 21215

30. Name and address of person who completed onuse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 2 1 2009

			State of Ma 1 - State Registrar	,	artment of Healt rtificate of Dea	th and Mental Hyg th Re	iene _{eg. No.} 2009	12638
	Dhusial		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Frances Blanchard Jacob			April	4c. County of Death	7:00 A M
. Age	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat Towson	ion of Death	Baltimo	re
	Funeral		BlakehurstCare Center 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Ur	nder 24 Hrs. 8. Date of Birth urs Min. (Month, Day,	9 Birthr	place (State or Foreign ntry)
	Director		215-10-9129 ^{1□ M 2} ▼F	93 Yrs.	Months Days Hou	urs Min. (Month, Day, March 12	2, 1916 Mir	nesota
	pur w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo-	cation		1	I0d. Inside City Limits
	Maryle f sho	io	Maryland Baltimore	Towson				1 ☐ Yes 2 🙀 No
	r 28a-	irec	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Cour	ntry?
	h with	Funeral Director	1055 West Joppa Road, Apt.	#716	21204		U.S.A.	
	r deal	nner	11. Marital Status 12. Was Decedent Armed Forces?		Was Decedent of Hispanion	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	14. Race - Americ Black, White,	
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Modical Exemples must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1⊡Yes 2⊠No <i>Sp</i> e	ecify:	Specify: Wh	ite
21215-0036	'2 hou	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	most of working	16b. Kind of Business/In	dustry
21	ithin 7 ne.	nple	Elementary/Secondary (0-12) College (1-4or	o+)	kind of work done during DO NOT use retired)	1	Federal Gov	ornmont
121	led w Hygier her th		12 17. Father's Name (First, Middle, Last)	Perso	onnel & Fina	Nother's Name (First, Middle, I		errmeric
Maryland	d be fi	Be C	Herman King Zuppinger			cy Boutell Boa		
aryl	shoull and Mark mark	2	19a. Informant's Name/Relationship (Type. Print)			umber or Rural Route Number		
Ž,	and 2 saith a 127 is er tra		Alfred Ritter / Friend			, Cockeysville		21030
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machael Exercitive must be redifficed at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponsion P	osition (Name of matory or other place) Service Corp	t .	20c. Location - City or Towson, Mar	
Balti	permit. Departn Importa any inju		21. Signature Fineral Service Licensee			ad, Towson, Ma		Home, Inc. 204
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not en	ter the mode of dying, suc	ch as cardiac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	bility				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):				•
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	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.					
oʻ	icate be executed physician and the burial-transit	Ex	resulting in death) Last Due to (or as	a consequence of):				
68760,	cate b	edical	d					
Box 6	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome				23d. Date of deliv	very
	death cer le attendin ed for use	Physician/Me	in the past 12 months?		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		Month	Day Year
P.0	that the de ned by the a detached f	hys	9 Unknowh			Part I 220 Did to	bacco use contribute to	the cause of death?
Records,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	b	Part II. Other significant conditions contributing to death I	out not resulting in the u	indenying cause given in i	1 N		obably 4 Unknown
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E B	The ate	Con			_		2 No 1 □ Yes	2 □No
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of		1. To	27 Manner of Death 28a, Date of Ini	ient 2 ER/Outpatie		Nursing Home 5 Resid	ow injury occurred	my)
<u>io</u>	Attending F r death. sctor: After by the funera	atio	1 Natural 5 Pending (Month, D 2 Accident investigation	ay, Year) Injury	M 1 □Yes	2 □No		
Division	I or Attend after death Director: /	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Ir building, e	jury - At home, farm, st tc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or Run n, State)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physician: To the besis and manners and manners	of examination and/or in tated.	nvestigation, in my opinio	n, death occurred at the time, o	date and place, and due	to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier		29c, License num	nber :	29d. Date signed (Month	, Day, Year)
			Heranders		258	505	HILL 20	2009
_	23	,	30. Name and address of person who completed cause of AND T CHARLES M	death (Item 23a) (Type 7 6701	N Charles	303 ST Tauson	NMO 1	1204
ì	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Jegis APR 2 1 2009	rar's Signature	arke			

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Physicia		1. Decedent's Name (First, Middle, Last) Dennel(11	Ferson		2. Date of Dea Month	ath Day	Year 7.005	3. Time of Death 3
/Medica Examine	r	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Lor Baltimore C			4c. County o	of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 215 90 3487 1 M 2 x 43	last birthday) Yrs.		Hours Min.	8. Date of Birti (Month, Day Dec. 2	h	9. Birthp Count	lace (State or Foreign ry) ryland
death with the Maryland ms 23a or 28a-f show must be notified at	.	Usual Residence of Decedent 10a. State 10b. County 10c. C MD n/a	ity, Town or Lo Balti					1	0d. Inside City Limits
with the 3a or 28a t be notiff	II Director	10e. Street and Number 3769 Lyndale Ave.		10f. Zip-Code			10g. Citizen of W	hat Count	ry?
ite er	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in UArmed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2 No	anic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)		- America K, White, e	etc.
vithin 72 hours affiene. than "natural", or the Medical Examin	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give life. I	dent's Usual Occupation kind of work done during NOT use retired)	ing most of workir	pg .	Baltin	nore	
	e B	GED 17. Father's Name (First, Middle, Last) Willie G. Jackson, Sr.			orker B. Mother's Name			e)	
lar 2 sh and is m	۹	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and	d Number or Rura	I Route Number		State, Zip	
item 2		1 Rurial 2 Cremation 3 Removal from State	Place of Dispo cemetery, crer	osition (Name of matory or other place) Cemetery	D	ate	20c. Location -	City or To	wn, State
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.	Č	2. Name and Address of a LVin B.	of Eacility Scrugg	s Fund	eral Ho	ome	21213 Approximate
Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Le to (or as a conse	2all c	ell lung	canc			-	Interval Between Onset and Death
8760, Cate be executed with the burial-transit and sthe burial-transit	edical Examiner	Sequentially list conditions, than, load good and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Line for a consecutive cause. Consecutive consec	,					- 5/1	
death certifi e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 Yes 2 No 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	er y Day Year
ds, P.O ires that the signed by th d be detach	۵	Part II. Other significant conditions contributing to death but not re	esulting in the	underlying cause giver	n in Part I.	23e. Did to			he cause of death?
Records, he law requires t e has been signe age 2 should be	Completed		,			24a. Was autop perfo 1 Yes	rmed:	orior to co death?	psy findings available impletion of cause of
	Be	25. Was case referred to medical examiner?	752/0.4	Othor	6. Place of Death			ne /Cnació	4
	ation: To	27. Manner of Death 1 Natural 2 Accident 2 No 1 Inpatient 2 Saa. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury a Work?			how injury occurr		<u> </u>
DIVISIO al or Attendil s after death. I Director: A	Certification:	3 ☐ Suicide 4 ☐ Homfcide 6 ☐ Could not be determined 28e. Place of injury - At the building, etc. (Spectors)		eet, factory, office	2	28f. Location (City or Tow		er or Rura	al Route Number,
spl nou ner	Medical (29a. Certifier (check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.							
To the Ho within 24 h To the Fu	Me	29b. Signature and title of certifier		29c. License n	umber - 000	,	April	Month,	Day, Year)
3		30. Name and address of person who completed cause of death (Its Anthony Sans	em 23a) (Type			lorth Wo	olfe St, Ba	Itimoı	re, MD, 21287
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's gr	face	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician DORIS LAVERN JONES Year 19, 2009 11:00A M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 611 Pontiac Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** Days Year! Months 1 □ M 2 🔀 F 217-16-3039 86 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Markeal Evaminer must be notified at 1 X Yes 2 No Director Baltimore Mary! and N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 611 Pontiac Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ White 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I and 2 should be filed within Fealth and Mental Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Montgomery Wards 9 Hair Stylist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Ellen Heckcrote Robert B. Fogler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra Doris Updike 225 Shipping Creek Drive, Stevensville, Maryland (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem. Pk. 4/22/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, PA 21. Signature of Funeral Service Licensee Kevin Ecker 237 E. Patapsco Ave., Balto., Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Syears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe this certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural after death.

I Director: Af in by the full 1 TYes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a

Physician; The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O.

72 hours after

Baltimore, Maryland 21215-0036

or Attending the Hospital

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

April 2014 2009

To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OO AM Day **Physician** 19 2009 apri /Medical Jan 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner arrol 8. Date of Birth (Month, Day, August If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number rs, last birthday **Funeral** 1 M M 2□ F Months Days Hours Baltimore Director mD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Completed by Funeral Director More 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt 1D cedent Ever in U.S. Forces? s 2 \(\text{No} \) 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was D Black, White, etc. rmed Forc Ves 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid Be ို Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Evans 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Cremation moall monktu) 01 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician c nsequence of): eal disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2[No 3 ☐ Probably 1 ☐ Yes 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) nours after death.

Ineral Director: After this y filled in by the funeral d 28a. Date of Injury 28b. Time of 27. Manaer of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 24

DHMH 17 Rev 1/2001

State Registrar 31 Date fil

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2009 12642

Janet Kahlor	1-	For State	State	of Maryland /	Certif	icate of	Death	a			Reg. N	0		
hysician		gistrar Decedent's Name	e (First, Middle,Last)						Date of D Month	Da	y Yea		Time of Death 0847 hrs
Me Examine	r .	Janet	Kahlor							April 16		4c. County of	of Death	
	4.	a. Facility Name (if St. Agnes H		e street and number)		4	b. City, Town, or Baltimore						n/a	place (State or
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Sec	ondary (0-12)	College (1-4 or 2	3+)	Truc	k Driv	er				Movin		
5-0036 ited within 72 Hygiene. I other than the Medical	탉		(First, Middle, Las					18.Mother			dle, Mai L 1 i	den Surnam	e)	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner.	}	20a Method of Di	sposition	Removal from		lace of Dispo	sition (Name of	cemetery,		Date		20c. Location Balti	n - City or	
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation	5 Other Specific	y: NST. Will:			Name and Addr Cremati 299 Fre					yland,	Inc.	21228
	_	One Part L Enter	the disease or cor	nplications that cause	ed the death.	Do not enter	the mode of dying	ng, such as	cardiac o	r respirato	ry arres	t, shock, or t	neart	Approximate Interval Between Onset and
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Division of Vital Records, pital or Attending Physician: The law requirements after death. erral Division After this certificate has been similed in by the funeral director, page 2 should b	Certification:	2 Accider 3 Suicide	0 0 13	not be 28e. Place	of Injury - At	home, farm, s	street, factory, of	fice building	g, etc.	28f. Lo	cation (Town, S	Street and N State)	umber or F	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Foureral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. transit			de	rsician: To the best	f examination	edge, death o	ccurred at the tir	me, date and pinion, death	d place, a	nd due to	the cau	-		
To the within To the comp	Medical		and title of certifier	and manner sta	ated.	,	29c. L	icense num				29d. Date April 19	signea (A	donth, Day, Year)
Ortod				who completed cause	e of death (Ite	em 23a)	Penn Street	Baltimo	re. MD	21201				
O'les	Stat	Jack Titue 31. Date filed		uty Chief Medic	al Examin gistrar's Sign									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Charles 2009 Glen Koontz 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Square Hospital Center Baltimore Koseda If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 1 M 2 F Vear) 219 22 5756 80 May 11,1928 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2☐No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 207 Riverthorn Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: white 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Steelworker Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ross R. Koontz Helen Hoestine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Bargar (daughter) 208 California Trial Browns Mill, NJ 08015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 4/21/2009 Overlea, Maryland 21. Signati re o Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part I. Byter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate aluse (Final disease or condition resulting in death) Myocardial Due to (or as a consequence of): oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 1☐ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner law requires that the death certificate be executed Physician/Medical

Physician

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

physician and s the burial-trans page 2 should s after death

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Be Completed

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician:

within 24 hours a

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 27. Manner of Death

(Check only

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0061907 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUKWAMA ESO, 1124 Male Avenue, Bultimore

31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Kolb 2009 April 12:15 AM Jean 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Middle River Ivy Hall Geriatric Center Baltimore Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Min. 1 □ M 2 🛛 F Hours 35 7/6/1973 Maryland 213-84-5890 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕱 No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8647 Town and Country Blvd. 21043 S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Nursing Home

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Jean Moore

Attendant

in than "natural", or items 23a or 28a-f show the Medical Examinant must be notified at Baltimore, Maryland 21215-0036 h and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any injury or other traumatic event Pages 1 ament of H

Physician

Examiner

Funeral

Director

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/Medical

Bonnie

10a. State

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17. Father's Name (First, Middle, Last)

Stephen Bernard Kolb

Director

Funeral

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Physician /Medical Examiner

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of Vital Records,

Division or Attending

- hours the Hospital the Funeral

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Examiner burial-tran and physician Physician/Medical the ası attending the þ signed to þ Completed cate has bage 2 s this certificate မ After thi funeral Certification: after death.

I Director: Ald in by the fu

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Step-Father) 48 Torque Way Middle River, Maryland 21220 Jeddy Blane Wilkinson, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/18 2009 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Deficiency Syndrome Immediate Cause (Final disease or condition resulting in death) Due to (of a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

cal

Mace Avenue, Baltimore MD 21221 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03065 State of Maryland / Department of Health and Mental Hygiene Beverly Kirby 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 17, 2009 0612 hrs **Medical Examiner** Kirby Beverly c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 5962 Daywalt Avenue Apt. F N/A 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs, last birthday Social Security Number **Funeral** Country) 549-78-7500 Days Min. Months Hours 59 25 Director 1949 M 2 X F Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location any 10a. State Yes 2X XNo N/A Baltimore or items 23a or 28a-f show must be notified at once MD imore, MD 21215-0036
Pages I and 2 should be fi ed within 72 hours after death with the Maryland neut of Health and Mental Physiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21206 5962 Daywalt Avenue Apt. F Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 X Married Yes Yes 2 X No specify: Specify:Black f Yes, Give Year 3 Widowed Divorced traumatic event, the Medi al Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MTA Fare Inspector 12th 2yrs. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Rozata Irvip 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis 2 19a. Informant's Name/Relationship (Type, Print) 503 Plaza Ct. Apt. A Aberdeen, Jessie J. Kirby-husband MD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition t: If i crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department o Important: injury or oth Garrison Forest VA 4/27/09 Owings Mills MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-Avenue Baltimore, MB^SZ1202 1101 E. North l on 23a. Part I. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit requires that the death certificate be executed Physician/Medica UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ Yes 2 No 3 ✔ Probably 4 Unknown Morbid obesity Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has To the Hospital or Attending Physician: The law performed? death? Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other₄ ER/Outpatient DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification 1 V Natural Yes 2 within 24 hours after death.

To the Funeral Director Pending the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 17, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Assistant Medical Examiner

Registrar's Signature

Melissa Brassell, MD

OCME

31. Date filed (Month, Day, Year)

			For State Registrar	State of Marylar		nent of F cate of I			giene Reg. No. 2	109 12616
	Physicia	an	1. Decedent's Name (First, Middle, Las	,	WALL CHE	n		2. Date of De Month	ath Day	Year 3. Time of Death 19:59pm
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,	Examin	er	FRANKLIN Square			,,	edale		1	LTIMOGE
	Funeral Director		Social Security Number 6. S		last birthday) If I	Under 1 Year onths Days			th ay, Year) -1916	9. Birthplace (State or Foreign Country) MARYLAND
	/land		10a. State 10b. County		ity, Town or Locatio	n				10d. Inside City Limits
	Ba-fsh	Director	MD BAL	TIMORE		R	OSEDALI	Ξ		1 □Yes 2 XNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mardal Hygiens. Department of Health and Mardal Hygiens. In Inportant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its Modified Examination of the Input of other traumatic event, Its Modified and once.	al Dire	10e. Street and Number 245 ATTENBOROU	GH DRIVE A	PT 101	Of. Zip Code	21237	7	10g. Citizen of V	Vhat Country?
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was	Decedent of H s, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Rac Blac	e - American Indian, k, White, etc.
Maryland 21215-0036	irs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【※Divorced	1	1 □ Y	es 2X No	Specify:		Specify	WHITE
	72 hou	eted	15. Decedent's Ed (Specify only highest gra	l ducation ude completed)	16a. Decedent's	of work done of	during most of wo	rkina	16b. Kind of Bu	usiness/Industry
	vithin ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	IOT use retired	ERVICE	9	Macol	OMTOVIC
d 2	filed v Hygic other	Be Co	17. Father's Name (First, Middle, Last,)	COSTC	JAIN S		me (First, Middle	, Maiden Surnam	RMICK'S
ılan	Jid be Jental rked c	To B	GEORGE	I	KNIGHT		MAGGI	E	(MERI	RYMAN)
¶ar⟩	2 should I and Men Is marke		19a. Informant's Name/Relationship (**						State, Zip Code) 21237
re,	1 and Health em 27 ther tu		MARGUERITE LAG					DR APT1		EDALE, MD City or Town, State
Baltimore,	Pages nent of int: If ite iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specif	Inemoval from State 🏲 T	Place of Disposition cemetery, cremator EN HAVEN	y or other place MEMO	RIAL 4-	-21-09		BURNIE, MD
alti	permit, Page Department of Important: If any injury or once.		21. Signature of Fund Servin Licer		22. Na	me and Addre	ss of Facility CV	ACH/RO	SEDALE	FUNERAL HOME
<u> </u>	8 3 E # 8	V.	100		121	I CHE	SACO AV	ENUE .	ROSEDAI	
		Q)	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the dea one cause on each line.				ac or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec		15 5	epsis			
	Examiner		Conversion line and distance	· ·	mbolism					
1-	ed sit	iner	Sequentially list conditions, in the sequential sequence of the sequence of th	Due to (or as a conse.						
<u> </u>	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Africe Fi	brillati	011				
8760,	ite be ysiciai ie buri		(_ d						
89 >	ertifica ling ph e as th	Physician/Medical	IF FEMALE:							
Box	eath c attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3 ☐ Ect	opic pregnanc	у			te of delivery onth Day Year
<u>Р</u> О	t the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	g ☐ Unknown	3000					
S,	es tha igned be det	by P	Part II. Other significant conditions of		_					ribute to the cause of death?
ord	requir			ic stroke,		ecolina	خ	1 📗	Yes 2∐ No	3 Probably 4 Junknown
Rec	ne law e has b ge 2 s	Completed		gic Anemic	L, HTN			24a. Was auto perfo	psy	Were autopsy findings available prior to completion of cause of death?
ta	an: Th tificate or, pa		hyoThyroidism 25. Was case referred to medical	Angina			26 Place of De		2 ANO .	1 □Yes 2 □No
<u></u>	nysici nis cer direct	ro Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Oth	or:		idence 6 □Oth	er (Specify)
Division of Vital Records,	ing P	:uo	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl		28d. Describe	how injury occurr	red
isio	Vittend death ctor: y the f	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b				Yes 2□No	28f. Location /	Street and Numb	er or Rural Route Number.
.≥	al or A s after Il Dire	Certification: To	28e. Place of Injury - At home, farm, street, factory, office determined determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (nysician: To the best of my kn miner: On the basis of examin and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	1		29c. Licens	e number		,	d (Month, Day, Year)
	. \		· Colu				50000		4/16	
	TH		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print	VIIN (Saura	2 NO	1301TO	ind 21237
	\vee		DR catherine	VINA 400	TOPHIL	- CIPL -		- hv	100000	1100 01601

Registrar

31. Date filed (Month, Day, Year) 22. Registrar's Signifure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** A.M 2009 <u>Edna T. Kehoe</u> April 18. 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Broadmead Retirement Center Cockeysville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 □ M 2 🖾 F Months 90 Nov. 1,1918 Maryland 218**-10-**1542 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 21 No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Schools Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ William C. Thomas Louise M. Walter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Personal Stephen Held 4228 Hoffmanville Road; Millers, MD 21102 Representative 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4-21-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 D Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No Were autopsy findings available prior to completion of cause of death? 2 ∏Nn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

be executed .09 attending physician for use as the buria 687 Box P.0. signed I Records, has certificate Vital After this certific funeral director, of Division Hospital or Attending after death Director: / within 24 hours after
To the Funeral Dire
completely filled in b

Funeral

Director

28a-f show

23a or

items

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"natural"

h and Mental Hygie

permit. Pages 1 and 2.
Department of Health a
Important: If Item 27 is

Physician

/Medical

Examiner

burial-transit

page 2

injury or other

Maryland 21215-0036

Baltimore,

traumatic event, the Medical Examinar must be notified at

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

RD., COCKEYSVIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 12648

ony 200 racin		- For State	tate of Maryi		ertificate	of Dea	th			Re	g. No.		
Physicia		Registrar 1. Decedent's Name (First, Mid	dle,Last)						2.	Date of Death	1	ear	3. Time of Death
edical Exami		Ricky Lee	Kitzmil]	Ler				_		Month April 17, 20	009		1750 hrs
		4a. Facility Name (if not institut	on, give street and nu	umber)			Town, or L	ocation of	Death		4c. County	y of Death	
		University Hospital					more					- 0 0	h (Distance)
Funeral	Ī	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Un	der 1 Year hs Days	If Under Hours	T 10			Foreign	hplace (State or
Director		218-02-8741	1X M 2 F		42	Yrs.	ns Days	Tiodis		05-06-	1966	Cou	untry) MD
	t	Usual Residence of Decedent	·										10d. Inside City Limits
, any		10a. State 10b. County			ty, Town or Lo								1 Yes 2 X No
and show	5	MD Ann	e Arundel		Millers								
Maryl 28a-1 d at o	ect	10e. Street and Number					ip Code			10	g. Citizen of \		ntry?
ith the Maryland 23a or 28a-f show notified at once.	卣	Rol-Park Trail					21108					S.A.	District Dis
h with	era	11. Marital Status 1 Never Married 2		cedent Ever in orces?	U.S. 13.	Was Deced If Yes, spec	dent of Hisp cify Cuban,	anic Origi Mexican,	n? (Spec Puerto Ri	ify Yes or No- can, etc.)	- 14. Ra Wh	ice - Ameri hite, etc.	can Indian, Black,
or ite	Funeral Director		1 Yes	2 X No			2X No	ann aife it			Specifi	y: Whi	te
s after	à	3 Widowed 4 X D	ivorced If Yes, Give Ye or Dates:		16a Dece		al Occupation		ind of wor	k done	16b. Kind of		
5-0036 led within 72 hours after the within 72 hours after the "natural", other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12		1-4 or 5+)			orking life.						
36 thin 72 te. than edical	ed l	10	.)	, , , , ,	P1	umber					Plu	mbing	g
5-00 ed with tygiene other	ĕ	17. Father's Name (First, Midd	e, Last)				1	8.Mother's	s Name (F	irst, Middle, I	Maiden Surnar	me)	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be	Kenneth Lec	n Kitzm	iller			ļ.	Mari		Gorman			
2121 ould be fil Mental I marked ic event,	2	19a. Informant's Name/Relatio				iling Addre	ss (Street	and Numi	ber or Ru	ral Route Nun	nber, City or T	own, State	e, Zip Code)
and 2 short ealth and lem 27 is traumatic		Mrs. Marie Kit	zmiller /		- 1	_							L1e,MD 21108
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Montal Hygient of Heath and Son and Hygien 17 is marked other than "natural", or items 23a or 28a-f sho in: If item 27 is marked other than "natural", or items 23a or 28a-f sho in other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Cremati	on 2 Romoval		b. Place of Dis crematory o			netery,	ı	Date	20c. Locatio	on - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other		A	tlanti	c Cre	mator	у	04-2	2-2009	Glen	Burr	nie, MD
Baltir permit. I Departm Importa		21 Signature of Funeral Servi			2	2. Name ar	nd Address	of Facility	2nd	Ave S	W Glen	Burr	nie, MD
E Pe W	V	Sulva).	Suck	M014									ces, P.A.
Physician		23a. Part I. Enter the disease, failure. List only one cau		caused the dea	ath. Do not ent	er the mod	e of dying, s	such as ca	ardiac or r	espiratory arr	est, shock, or	heart	Approximate Interval Between Onset and
/Medical xaminer	0 10	Immediate Cause (Final disea	_{se a.} Multiple G	iunshot Wo	unds								Death
Xaiiiiici		or condition resulting in death	Due to (or as	a consequence	e of):								
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776 ficate g phy s the b		IF FEMALE: 23b. Was decedent pregnant in	tho	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month						Day Year			
ox 68° eath certification attending for use as	sician/	past 12 months?	4 Pre	gnant at time of		Other (S					1		
Box 687 e death certific the attending perfections as the	ysi	1 Yes 2 No 9	9 Olik	nown									(1 - 4 - 2
P.O. B s that the d gned by the e detached	y Phy	Part II. Other significant con	ditions contributing	to death but n	ot resulting in	the underly	ing cause g	jiven in Pa	art I.				o the cause of death?
ires that signed!	by by												
cords aw requinas been as been 2 should	ete	1								24a. Was	psy	prior to	autopsy findings available completion of cause of
Records, The law requir ficate has been s	Completed										ormed? 2 No	death? 1 ✔ Y	The state of the s
Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to med	ical				26.Place	of Death	(Check or	nly one)			
Vita hysicia this ce Il direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	✓ ER/Outpa	tient 3	DOA	Other ₄	Nursing	Home 5	Residence	6 Oth	er:
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending, competely filled in by the funeral director, page 2 should be detached for use as the competency filled in by the funeral director, page 2 should be detached for use as the content of the conten	⊢	27. Manner of Death	28a. Da	te of Injury oth Day Year) 7, 2009	28b. Time		1 _	ry at Work	. IF		how injury oc		
ion tendii eath. for: A	[흝		ending Apr 17	7, 2009	UNKNO	WIN	1 1	Yes 2 ✓	No				
Division To the Hospital or Attend within 24 hours after death ro the Funeral Director: completely filled in by the	Certification:		ould not be 28e. Pl	ace of Injury - A	At home, farm,	street, fact	ory, office b	ouilding, et	tc.	28f. Location or Town,	(Street and No State)	umber or R	Rural Route Number, City
Divisi Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by	le L	4 V Homicide		y) Single F							State) rfield Rd., So		
Hos 24 hc Fun etely	1	29a. Certifier 1 Certifying	Physician: To the basi	est of my know	vledge, death	occurred at	the time, da	ate and pla	ace, and o	due to the cau	use(s) and ma	nner as sta	ated. the cause(s)
Signature of the signat	Medical		and manne	r stated.	on and/or inve	sugation, in				the time, date		_	fonth, Day, Year)
	Σ	29b. Signature and title of cer	tifier				29c. Licens						ionin, Day, rear)
		l'au ol	Hall	d iv			O.C.	IVI.E.			April 18	, 2009	
5		30. Name and address of per			—	nn C/	4 D-14:	ore MA	24204				
N. S.			Assistant Medica			nn Stree	t, Baltim	ore, IVIL	2 1201	· · · · · · · · · · · · · · · · · · ·			
S Regis	State		ar) 32.	Registrar's Sig	nature								
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** King 12:08 A M Margaret Apr 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 22, 9. Birthplace (State or Foreign MD ountry) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 1 Months Hours 1940 Days 218-38-2060 69 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits the Maryland 28a-f show r than "natural", or items 23a or 28a-f show ¥Nes 2□No Director Carroll Westminster MD 10e. Street and Number 10f. Zip Code 21157 10g. Citizen of What Country?
United States Pages 1 and 2 should be filed within 72 hours after death with 102 Timber Ridge Dr. APT 319 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 □Yes ŽŽNo Specify. Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 127 is marked other than "r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) self-employed Caregiver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surgame) Annie Clementine Smith Be William Harrison Lyles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Carolyn Cooper (niece) permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr. 851 Streaker Rd. Sykesville, MD 21784 20a. Method of Disposition
1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date S. Carroll Crematory 4/25/2009 |Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Sepsis 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 weeks Pseudomonal Pneumonia Sequentially list conditions, Divi to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 2 weeks C. Diff Colitis burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending philosophers IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAD NSTEMI 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a Was an autopsy 2,200 1 ∐Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

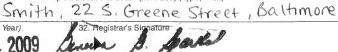
⊋ ✓ State

31. Date filed (Month, Day, Year)

APR 2 1 2009

Catherine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

MID.

19,2009

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Dayo, 2000 Month RIL 6:48F Eugene Kmiec, Jr. 4c. County of Death 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign New York

10d. Inside City Limits

Approximate Interval Between Onset and Death

MONTHS

YEARS

Day

2 No 3 Probably 4 Unknown

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

Year

23d. Date of delivery

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy perform res 2

28d. Describe how injury occurred

U.S.A.

14. Race - American Indian Black, White, etc.

Specify: White

Music

1 ☐ Yes 2 ☑ No

1. Decedent's Name (First, Middle, Last) **Physician** John /Medical 4a. Facility Name (If not institution, give street and number) Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 21. 5. Social Security Number **Funeral** 1 ₩ M 2 □ F 090-26-0146 74 Director Usual Residence of Decedent 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD **Baltimore** Cockeysville 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 21030 400 Symphony Cir #159 Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. ð 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, the ones. Distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Kmiec, Sr. Marianne Szmvtkowski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 400 Symphony Cir # 159 Cockeysville, MD Jean Kmiec-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Serv Corp 4/24/09 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC SMALL CELL CARCINOMA OF **Physician** /Medical Due to (or as a consequence of) Examiner THE LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed END STAGE CHRONIC OBSTRUCTIVE PULMONARY Due to (or as a consequence of) burial P.O. Box 68760, attending physician for use as the huria DISEASE Physician/Medical the as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ

signed I Division of Vital Records, has page 2 certificate Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica itely filled in by the funeral director, p

Completed Be မ Certification:

25. Was case referred to medical examiner?

29b. Signature and title of certifie

1 🗌 Yes

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

within 24 hours aft

To the Funeral Di

completely filled in Medical To the within 7 State Registrar

LILIA CEBALLOS M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 □Could not be

28a.

Date of Injury
(Month, Day, Year)

and manner stated



1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe D 25886

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, perInf G890 4/27/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 9 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death nolman APRIL 2009 12:15 P ^M 14 nena 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BRIGHTWOOD NURSING HOME BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/31/1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF ŐΚ 90 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 ATRIUM COURT, #225 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **OWNER** GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JOSEPH FLEISHMAN** MOLLIE KLAVANSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5712 OAKSHIRE ROAD, BALTIMORE, MD IRA KOLMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP 04/19/2009 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Sign fure if Funeral Sourice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cardiomyorathy

Physician /Medical Examiner

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

or 28a-f show

death

r than "natural", or Iteme 23s or the Medical Examinar must be

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and I flem 27 is marked other than "natural; or ite and prove than that marked other than "latural; or or other thatmatic event, the Madical Examinal by or other thatmatic event, the Madical Examina

Baltimore, Maryland 21215-0036

Direct

Funeral

Completed by

Be

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner Be Completed by Physician/Medical Medical Certification: To

Soquertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.	melling identiq nston		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco of the second	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical		26. Place of D	eath (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injur	ry occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, B)	
29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exem	ysicien: To the best of my knowledge, dea iher: On the basis of examination and/or i and manner stated.	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ce, and due to the cause(s curred at the time, date and) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Da	te signed (Month, Day, Year)
	~~	272749	1 04	0-15-09

DHMH 17 Rev 1/2001

State

Registrar

W

5/540

30. Name and dedress of person who completed cause of death (Item 23a) (Type, Print)

TOWSON

32. Registrar's Signature

2. HIRPARA MO

1 2009

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2652 Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 9:15 P M Keefer 2009 Apri1 5 Muriel Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Tate Hospice Center Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 20, 1934 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🔏 F 74 Director 219-32-1782 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Vedical Evantiner must be notified at 1 □Yes 2X1No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 7731 Middlegate Court 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💥 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A <u>Van Driver</u> Providence Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fill f Health and Mental H tem 27 Is marked otl other traumatic even ပ Raymond Ε. McCov Anna Barrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important; If item 27 any injury or other tra Donald W. Keefer (Husband) 7731 Middlegate Court Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Pk. 04/18/09 Elkridge Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee <u>3204 Mountain Road Pasadena, Maryland 21122</u> 23a. Part1, Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Smal VIS 0n-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed and burial-tran Due to (or as a consequence of): attending physician the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ director, page 2 should be Retradory Amenio Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy perform certificate 1 ☐ Yes 2. No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No House 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **≯** Natural 5 Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. the within 7 rise numbe 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item, 23a) (Type, Print) Year, 31. Date filed (Month, Day, egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 19, 2009 Year **Physician** MARJORIE ODELL LAWRENCE 6:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Care Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 13, 1925 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 235-38-2976 Months West Virginia 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lighty or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6520 Walther Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 If Yes, Give 1 Never Married 2 Married 1 □Yes XXNo White Specify: ģ 3₹Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rilles Smith Beatrice May Hayes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Lawrence-Huerta DTR 8106 Ridgetown Dr #D Baltimore, Maryland 21236 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory April 21,2009 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John 0 Mitchell, IV Funeral Services of gnature of Funeral Ser 23a. Part 1. Enter the disease, it complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Dulaney Valley PA 200 East Padonia Road TimnoiumMD Approximate 21093 Interval Between Onset and Death Immediate Cause (Final LSCHEMIC **Physician** (ardiomy opathy disease or condition resulting in death) 44151 /Medical Due to (or as a consequence of): Examiner descare artay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 663 Huchne 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 LYNo 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Sother (Specify) WSPLY 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ر attending physician and for use as the burial-tran been signed by the should be detached this certificate ours after death.

neral Director: After this certific filled in by the funeral director, 24 hours a

Baltimore, Maryland 21215-0036

within 2

State Registrar

Medical

MARIEN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

MD applies

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles

29c. License number 1) 58303

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) AMIL 19 2009

DUSON MO

32. Registrar's Signature parke

/Medical Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician for use as the buria Division of Vital 24 hours a the

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfall Eventhal Eventhal Be notified at once.

Physician

Maryland 21215-0036

altimore,

the Maryland

detached director, page 2: s after dea. ral Director: Aft filled in by within 2.

Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No ٩ Certification: 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 2009 (se(n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Store CHAUCO 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 2 1 2009 Registrar

		4	State of Maryland / Departm	nent of He cate of De			2000	12655
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	J. No. 2 U U 9	3. Time of Death
_	sicia	n	Robert W. Lloyd.			4001 1	Tay 2009	0831 AM
	ledica amine		4a. Facility Name (If not institution, give street and number) 4b. (ocation of Death		4c. County of Death	
	0		Johns Hopkins Bayview Medical Center	Baltima Inder 1 Year		8. Date of Birth	n/a	place (State or Foreign
Fund Direct					Hours Min.	(Month, Day,) 02/02/	71943 MAR	YLAND
		1	Usual Residence of Decedent					(C) 1: 7
arylan	Ħ	.	10a. State 10b. County 10c. City, Town or Location PALTIMOR:					10d. Inside City Limits 1X Yes 2 ☐ No
the Ma	offile	Director	110 11/4	f. Zip Code		100	g. Citizen of What Cou	
with 3a or	2		5011 EAST BIDDLE STREET		1205		JSA	
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show	acolcher, mas	by Funeral	Armed Forces? If Yes, 1 □ X Never Married 2 □ Married If Yes 2 □ X No If Yes 2 □ X No If Yes 2 □ X No If Yes 3 □ Yes	, specify Cuban,	panic Origin? (Spec , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WH	
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. 27 is marked other than "natural", or	EX EX	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's	Usual Occupati	ion	10	6b. Kind of Business/Ir	ndustry
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d 21. filed with Hygiene other tha		Sol	12 0 DISAB			(F) -1 2 4 3 4 4 5 - 2 4	n/a	
and lbe fill ed oth	even	Be	17. Father's Name (First, Middle, Last) ELZIE LEON Lloyd		8. Mother's Name MARY H		CHVOJAN	
arylan should be and Mental	ımatic	ဍ					City or Town, State, Zi	p Code)
and 2 and 2 a ealth a n 27 is	er trau	1		AST BI	DDLE ST	REET B	ALTIMORE,	MD 21205
altimore, rmit. Pages 1 ar partment of Hea portant: If Item	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crematory.	y or other place))		0c. Location - City or T	
Baltimor permit. Pages Department of Important: If It	jary		4 □ Donation 5 □ Other (Specify) METRO CRE	MATORY	1		BALTIMORE	•
Balt permit. Departr Import	any injury or on once.		12	11 CHE	SACO AV	E BALT	IMORE, MI	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				st,	Approximate Interval Between Onset and Death
Physic /Med	_		Sequentially list conditions if any, leading to improve cause on each line. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) last	nary	arres	1		
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D _D	ti.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	100				
and and	l-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	7 0001	<u> </u>			
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687 tificate ig phy	as the	ledic						
. Box 68 death certific e attending p	r use	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 3 □ Ects	opic pregnancy			23d. Date of deli	very Day Year
P.O. E at the dea by the at	hed fo	/sici	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 5 □ Othe	er (specify)			World	bay tou.
IS, P. res that th signed by	detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds quires en sigr	nd be	d by				1 ☐ Yes	s 2 No 3 Pro	obably 4 Unknown
Division of Vital Records, P.O I or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the	2 shoi	Completed				24a. Was an autopsy	24b. Were aut	topsy findings available completion of cause of
The l	page	E				perform	ed? death?	2 🗆 No
Vita ician: pertific	director, page	Be	25. Was case referred to medical examiner? Hospital:	Othor	26. Place of Death			
Of Phys	ral dir	음	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury : Work?	4 L Nursing Hor	ne 5 Resider	nce 6 Other (Spec winjury occurred	eify)
ion nding th. : Afte	e fune	tion	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation N		es 2 No			
Division of lor Attending Phys after death. Director: After this	by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	2	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Dital o	filled in		360 111 111 111 111 111 111 111 111 111 1		- 4-44		augusta) and manner of	otatad
Hosp 24 hours Fune	etely f	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigener and manner stated.	gation, in my op	inion, death occurr	ed at the time, da	ite and place, and due	to the cause(s)
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I	completely	Me	29b. Signature and title of certifien	29c. License	number	29	d. Date signed (Month	
	-		Gadore U. Leldman, MD	1020	56 76		tpril 17,	2009
/	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I sado re A. Feldman Johns Hop 31. Date filed (Month, Day, Year) APR 2 1 2009 APR 2 1 2009	Kine T'	& Bauli	(len)		
家	Sto		31. Date filed (Month, Day, Year) 32. Registrar's Signature	2113	1	-		
Re	Sta gistr		APR 2 1 2009 Seven S. Jak					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 1:15 A M **Physician** 14, 2009 April Erna Catherine Lettau /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Anne Arundel Tate Hospice House Linthicum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 16, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 □ XF Months Days Mary land 219-16-4264 83 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Glen Burnie 1 TYes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 United States 307 King George Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 Factory Worker General Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie May Clayton t and 2 should by Health and Ment Frederick Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Keidel - Daughter 307 King George Drive., Glen Burnie, MD 21061 item permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Glen Haven Methor 121 Surial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4-17-2009 □Other (Specify) 4 ☐ Donation Park 21. Signature of Fundral Sarvice Li 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION DNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner ORO FHARYNG BAC

Due to (or as a consequence of): Securitally list our differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit CEREBRO VASCULAR and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the Ö 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**/2** No 1 ☐Yes ≥ No 1 ☐ Yes al or Attending Physician: safter death.
Il Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) \(\text{HDS PIC S} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

<u>~</u> Division of Vital Records, To the Hospital within 24 hours a To the Funeral D

29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 K.Ambalavanar

29d. Date signed (Month, Day, Year) 29c. License number April 14 2009

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alen Burnie, MD 21061

State Registrar

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Ira Thomas Laumann, Sr. 6:15 AM APRIL 16 2009 4a. Facility Name (If not institution, give street and number) Union Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 1, 1955 7. Age (In yrs. last birthday) Months 1**XX**M 2□ F 213-60-0605 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Director Baltimore XXX s 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2943 Keswick Road 21211 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1√Xes 2 □ No If Yes, Give 1975 Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify ģ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oles Envelope 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Laumann Adele Belts ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Virginia Laumann (Wife) 2943 Keswick Road Balto, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Crestlawn Memorial 04/20/09 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burgee-Henss-Seitz Funeral I 3631 Falls Road Balto, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) JEPSIS OF NEUTROPENIA Due to (or as a consequence of): FAILURE RENAL Sequentially list conditions, if a second of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of KESPIRATORY PAILURE SECONDARY TO PNOWIMENIA Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav Ye ar 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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ed other than "natural", or items 23a or 28a-f showevent, the Medical Even in registral by nothing at

the Maryland

death with

72 hours after

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany Injury or other traumatic event in any Injury or other traumatic event

Physician

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Examiner

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aftending physician for use as the buria

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Medical

Saltimore, Maryland 21215-0036

signed by the a The law requires that Division of Vital Records, cate has been si page 2 should k certificate Attending Physician: e Hospital or Attending Ph 124 hours after death. e Funeral Director; After th completely filled in by the funeral e Funeral To the within 2

ZAHRA 31. Date filed (Month, Day, Year) State Registrar APR 2 1 2009

4 Homicide

29b. Signature and title of certifier

29a. Certifier

determined

PAKSAL (Yesidend) (MD)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

APRIL 16, 2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend, #17 per FH G890 4/27/09 Tr
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician 18 05:47 04 2009 Lewis Alfonso Roscoe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 218-01-9715 07 Director 06 VA 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Examinar must be notified at 1 □Xes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21215 3326 Sumter Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Adm. d 2 should be filed with and Mental Hygier 7 is marked other the Foreman 12th grade na 17. Father's Name (First, Middle, Last)
Solomon 18. Mother's Name (First, Middle, Maiden Surname) Be Susie King Soloman Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2::
Department of Health a Important: If item 27 is any injury or other trauonce. 3822 Mary Ave, Baltimore, Md 21206 Wanda White-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Crownsville Vet. 4/24/09 Crownsville, Md Funeral Service Licen 22. Name and Address of Facility
March F/H West 21. Signature 4300 Washash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1 Enter the dilease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart if it re. List only one cause on each line. End. Stage demention likely 25 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** result is to such deservations Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cor sequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 🗹 No been signed by the a should be detached? P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 12No of Vital To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Altonso 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04.13.2009 D041476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 65 K. CHARLES ST, STE 416, BALTIMORE, MD RAYMOND W. WILSON M.D. Registrar's Signature 31. Date filed (Month, Day, Year) 32. State Dark Registrar

4118/09

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 9:20 P M Helen Wanda Link 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Parkville Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 29, 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Min Months Days Hours Country) Maryland 1 □ M 2 🕱 F 212-12-0557 87 1921 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🕇 No Maryland Baltimore Parkville 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21234 8830 Walther Blvd., # RGT230 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Specify. 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wanda Kowolski Koch Anthony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 W. Saratoga St., Baltimore, Maryland 21201 Richard Link / Son 20b. Place of Disposition (Name of Dulaney) Temperatury or other place) Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-23-2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. owson, Maryland 21204 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiomyopathy Due to (or as a comequence of): Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any lauding limits and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

attending physician and for use as the burial-tran

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within 24 hours a

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Physician

/Medical

Examiner

10a State

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

Completed by

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Injury or other traumatic event, the Medical Examiner must be notified at

"natural"

permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat, any highly or other traumatic event, the Medical once.

death with the Maryland

Baltimore, Maryland 21215-003

Examiner Physician/Medical Completed by Be

Certification: To

ical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No. 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manne of Death

Natural

3 ☐ Suicide

2 Accident

4 ☐ Homicide

(Check only one)

autopsy performe 2 No

Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

	26	Place of Dea	th (C	heck only one)	
OA	Other:	Marsing H	ome	5 Residence	6 ☐ Other (Speci
	Injury at Work?		28d.	Describe how inju	ury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number R171944

29d. Date signed (Month, Day, Year)

mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who q

Hospital:

28a. Date of Injury (Month, Day, Year)

Walther Blvd, Parkville, MD 2/234 G.

31. Date filed (Month, Day, Year)

5 Pending

and title of certifier

investigation

determined

6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Cup

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year VIRGINIA C. LANASA **Physician** 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Marylan Air lea H mo EHMBILITATION Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year Days Hours Months 1 ☐ M 2 😿 F July 10, 1921 219-05-5859 Maryland 87 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County Chester Maryland 1 ☐ Yes 2 X No Queen Annes Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be i 21619 USA 1709 Bayside Drive filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife & Mother Homemaker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other the any injury or other traumatic event, the once. 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Clark Robert E. Freburger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert V. Lanasa (Son) 1709 Bayside Drive, Chester, Md. 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial Gdns. 4/18/09 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, F.A. 21. Signature of Fundal Selvice Licensee Kevin E Ecker 130 Fast Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one can line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any. leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 □Ectopic pregnancy for Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the detached the been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ₽ 2 No 3 ☐ Probably 4 ☐ Unknown (ce 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 207No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes P this 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No i or Attend after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical o the Hr within ? To th 290. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature

State Registrar

31. Date filed (Mohth, Day,

Year

Name and addre

32.

of person who completed cause of death (Item 23a) (Type, Print

308 Busines

•	1-	For State Registrar			
	1. D	ecedent's Name	(First.	Middle.	Last)

State of Maryland / Department of Health and Mental Hygiene

	Regis
	1. Decede
ian	Mar
Icol	

Certificate of Death

Heg	. NO.		
2. Date of Death		 3.	Time of Death

Physician
/Medical
Examiner

Funeral Director

death with the Maryland 28a-f shov

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at

Maryland 21215-0036

Baltimore,

18,

Physician /Medical Examiner

and attending physician and for use as the burial-tran the Ś signed has certificate this

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 filled in by the funeral After Director: 24 hours a within 2

MARLENE

Month . 2009 ene Carol Lavery 18, 9:40 P M April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🕱 F 186-30-5055 68 5/3/1940 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location WV Hedgesville Hedgesville 1 ☐ Yes 2 👿 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 25427 1143 Winter Camp Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilhelmina Mabius Herbert Welday 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1143 Winter Camp Trail Hedgesville, WV 25427 Lavery / Husband Robert G. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/22/2009 Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Me Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that exceed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) APPENDICEAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}X$ Other (Specify) **HOSPICE** 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier Check only 2 Medical Examiner: On the basis of examiner Nurse Practitioner er stated. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10e&19b, perFH, G890, 4/28/09, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Oak Crest - Renaissance Gardens Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 24, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) X:ISAM **Funeral** Days Hours Months **№** M 2□ F Washington 537-16-8349 Director Usual Residence of Decedent r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Marylan 10b. County 1 ☐ Yes 2X No **Funeral Director** Parkville <u>Maryland</u> Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or with 21234 **USA** permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and lental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the "secioal Event incrimists once. 8800Wather Blvd. Ridgely Court Apt. 3422 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 No 1943 If Yes, Give Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Matin, Physician Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Martin Lillian Carlson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Dorothy Martin, Wife</u> 8880 Wather Blvd. Ridgely Court Apt.3422 Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/21/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor ^{22, Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) adenocarcyon **Physician** 9a Stric /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Day Ye ar 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | INC Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1011 30 Name and address of erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Class 32. Registrar Signa State APR 2 1 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Nelson 6:20 PMM April 20 2009 Charles Montgomery /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkville 8707 School Road If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 7, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1**火** M 2□ F 225 12 2076 88 Director West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2√∑ No Funeral Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 U. 823 Martin Road S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Repairman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd 2 should be fill thand Mental H 27 is marked ott traumatic even Unk. James Montgomery ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar em 27 is 1919 Glen Cove Rd. Darlington, Maryland 21034 Robert Montgomery (Son) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 Marial 2 Cremation 3 Removal from State Gardens of Faith Mem. Gard. 4/24/2009 Overlea, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that crused the death. Do not ent of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus a cardiac earn line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy forι in the past 12 III No NA Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence Hospital: 1 ☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and Me ATTERN RLUD. ESSEPTIM 2/22 Person who completed cause of death (Item 23a) (Type, Print) Mame and address of egistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:50 7 M Physician 2009 MORGAL 1 DROTHY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ATOUSYTL If Under 24 H DALTIHORE KEDGEWAY HANDE MURSEUG & KEH. Year Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. Months 1 ☐ M 2 ☐ XF 21, 1908 100 Nov. Maryland Director 212-01-2827 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at 1 Yes 2 No Maryland Baltimore Catonsville Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 16 S. Beaumont Avenue Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Black. White, etc. 1 X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bank Personnel Specialist 12 injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Heiderich James W. Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 S. Beaumont Ave; Catonsville, Maryland 21228 M. Bernadette Morgan Sister Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Loudon Park Cemetery 4/22/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21 Signi ture of Funeral Sery ice Lice she MD 1630 Edmondson Avenue; Catonsville, 21228 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 23a. Part1 Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Physician Theumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Presenal Azotemia, Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed Chrenic Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl inlatension autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 1 Yes 2 No 2 5 ☐ Residence 6 ☐ Other (Specify) After this c 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 3 🗌 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, lactory, office building, etc. (Specify) determined 4 T Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 187541 alltra Vara 41) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJAMO, 4367 Hollins form Rd, Baltimore, MD 21227 CLEETHA 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per Inf. C895, 9/30/09 TT

Amend 19a, per Inf. C895, 9/30/09 TT

Amend 19a, per Inf. C895, 9/30/09 TT

			Amend 193, Per 1 G033 7500 State of Maryland / Dep 1 - State	artment of Health and N ertificate of Death		
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	.No. 2003 3, Time of Death
	Physicia /Medic		Stanley W. Myllo		Month April	Day Year 2009 05:01 P M
and the	Examin		4a. Facility Name (If not institution, give street and number)		4c. County of Death	
مر			Pear Tree House	Pasadena		Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) MD
			Usual Residence of Decedent		1	
	ylanc		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mar a-fsl	ctor	Maryland Anne Arundel	Pasadena		1 □ Yes 2 ☑ No
	h the	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
	h wit	al	8004 Shadow Lane	21122		USA
	deat	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinant the rofflied at once.	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced Armed Forces? 1 Never Married Porces? 1 Never Married Forces?	1 ☐ Yes 2 ☐ No Specify:	· insuri, stor,	Specify: White
2-00	72 hour	eted	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work		5b. Kind of Business/Industry
21215-0036	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) rument Technician		Manufactoring
9	Hygi Hygi ther	ပို	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
Maryland	d be ental ced o	o Be	Stanley Myllo	Virgin	ia Sh	ore
2	thoul	은		ling Address (Street and Number or Ru		
Ma	nd 2 s Ith ar 27 is 27 is		Cheryl Ann Myllo (Dunford)	Milburn Circle, Pa		ID 21122
ē,	tem tem			position (Name of	Date 20	Dc. Location - City or Town, State
JO L	ages ent of nt: If i		1 🔀 Burlai 2 🗆 Cremation 3 🗆 Removal from State	· · ·		asadena, Maryland
Baltimore,	permit. F Departm Importar any injur		Titl. Gull	ICT CCMCCCT	entraries and the second	Funeral Home, P.A.
<u> </u>	9 9 E 8 9	Va 1	Dy L Day	3111 Mountain Ro		
			23a. Part 1. Enter the disease, or complic tions that crued the death. Do not eshock, or heart failure. List only one cause of each line.	nter the mode of dying, such as cardiac	or respiratory arres	at, Approximate "Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition			dwell/
1	/Medical Examiner		resulting in death) Due to (r as a consequence of):			Ducas
	LAMIIIIICI	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			ryears
	ted	ije	cause. Enter Underlying			
	execu al-trai	Examiner	that initiated events resulting in death) Last C			
8760,	icate be executed physician and the burial-transit	dical	d			
9		ledi				
Вох	eath certific attending p for use as	N/L	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	☐ Ectopic pregnancy		23d. Date of delivery
O. B	e deal	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	Other (specify)		Month Day Year
Ф.	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part	23e Did toba	acco use contribute to the cause of death?
Division of Vital Records,	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	d by	Tatti. Other arginioan community to deal of the following in	underlying educe given in taken	1 □ Yes	2 No 3 Probably 4 Unknown
CO	w rec s bee	lete			24a. Was an	24b. Were autopsy findings available
Re	The law ate has bage 2 s	Completed			autopsy performe	prior to completion of cause of death?
ital	ian: rtiffica ctor, p	Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
+	Physician: r this certific ral director, I		examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpat	ent 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residen	ice 6 Dether (Specify) Attail Fel
o u	ing P	:uo	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	Work?	28d. Describe how	rinjury occurred
sio	Attending It death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	20f Location (Stre	eet and Number or Rural Route Number,
ΟĬ	I or At after o Direc d in by	Certification: To	determined determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	treet, factory, office	City or Town,	State)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only (Check only 40 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the ca arred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	o the l	Medical	one) and manmer stated. 29b. Signature and title of pertifier	29c. License number	29	d. Date signed (Month, Day, Year)
	->-O		· Elket Arbet in	120094	4	1/20/0g
	PX,1		30. Name and address of person who completed cause of death (Item 23a) (Type Completed Cause of death (Item 25a) (Printleson Pork Ar	we Cla	buthe, and, 21041
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 1 2009 32. Registrar's Signature	- A B	,	
			THE THE PART OF TH			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland	/ Department of I		Hygiene 009 12667
	Physici /Medic		1. Decedent's Name (First, Middle, L	Catherine	McWill	10MS 2. Date o	Day Year 9 210 M
	Examin		4a. Facility Name (If not institution, g St. [- 12a et	Nursing Ce	nter Ba	or Location of Death	4c. County of Death N/A
	Funeral Director		5. Sociat Security Number 6. 214-01-1332 Usual Residence of Decedent	Sex 1	t birthday) If Under 1 Year Months Days	Hours Min. 8. Date o	f Birth, Day, Year) 10, 1912 9. Birthplace (State or Foreign Country) Maryland
	Maryland f show	ō	10a. State 10b. County MD N/A		Town or Location		10d. Inside City Limits 1 ☐ Yes 2√∑ No
	r 28a-	Director	10e. Street and Number	рат	timore 10f. Zip Code		10g. Citizen of What Country?
	23a c	alD	3320 Benson Av	e	212		USA
900	72 hours after death with the Maryland neturel; or Hems 23a or 28a-f show likal Exantratics Indiffied at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	dispanic Origin? (Specify Yes of an, Mexican, Puerto Rican, etc.) Specify:	r No-) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036		Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b. Kind of Business/Industry
	filed w Hygiei otherti		17. Father's Name (First, Middle, Las	N/A	Bottler	18. Mother's Name (First, Min	Seagrams ddle, Maiden Surname)
lan	fental rked o	To Be	Robert C. McWi				minant
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	and Number or Rural Route No	umber, City or Town, State, Zip Code)
	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 Is marked other than or other treumatic event, tha Me		Thomas A. McWi				anover, PA 17331
nor	Pages nent of I int: If it		1 ☐ Burial 2 🏋 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	Hemovariiom State	ce of Disposition (Name of netery, crematory or other pla intic Cremator	1 -	Glen Burnie, MD
Baltimore,	pernit. Pag Dep riment Importent: I any injury o		21. Signature of Fundamental Control of Funda		22. Name and Addre Lemmon Fu	ass of Facility	Oulaney Valley, Inc.
	, B		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. ly one cause on each line.			
	Pnysician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a and	rexia		menths
5	Examiner			Due to (or as a consequent	T	al fibrill	ation years
8760,	cate be executed by sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence)	nic obtru		monary diease years
687	ficate p physics ts the l	edlo		d		/=	
O. Box	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 Ectopic pregnance	у	23d. Date of delivery Month Day Year
rds, P.	quires that the signed by all be detacted	by	Part II. Other significant conditions	contributing to death but not resulti	ing in the underlying cause gr		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ★No 3 ☐ Probably 4 ☐ Unknown
I Records,		Completed					Was an autopsy available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospitali	100	26. Place of Death (Check o	nly one)
of	Physic rthis or ral dir	To :	1 Tes 2 No 27. Manner of Death		3/Outpatient 3 □ DOA □ Bb. Time of Injury ■ 28c. Injury		Residence 6 Other (Specify)
ion	Attending F r death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigat			rk?]Yes 2 □ No	
Division	ospitet or Attendents after death hours after death unerel Director: ly filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine		e, farm, street, factory, office		on (Street and Number or Rural Route Number, r Town, State)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of my knowle eminer: On the basis of examination and manner stated.	edge, death occurred at the tin and/or investigation, in my	me, date and place, and due to opinion, death occurred at the ti	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	mon	29c. Licen		29d. Date signed (Month, Day, Year)
,			30 Name and address of a second	o completed and of death them?	(3a) (Type Print)	5591	1tpril 20, 2009
) V	ate	30. Name and address of person when the second seco	320 Benson A	Frenue, B	5391 altimore, ll	Maryland 21227
	Regist		APR 2 1 2009	32. Registrar's Signatur	tak		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2:00p M **Physician 1**8 2069 MArgaret M. Mundey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8 Lyndale Avenue Nottingham Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF 219-28-1815 76 Director July3,1932 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if Marked Exyminal Landlish at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Baltimore MD Director Nottingham 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 Lyndale Avenue 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify. Specify: White ģ 3 Widowed 4 ☐ Divorced Ye ar or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Woolworth 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles McEvoy Alice မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Mundey/daughter 8 Lyndale Avenue Baltimore MD 21236 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition OAK Lawn Cemetery 4/23/09 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Zheimer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last g physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/Natural 2 ☐ Accident 5 Pending investigation of the safter death.

E Funeral Director: Af letely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mil 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Digital Dreive, 6 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 17 2009 Marsili, Sr. April 3:30 p M Robert Louis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 241 Albermarle Street n/a Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 13, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1931 Days Hours Months 218-26-3972 Maryland 77 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits nd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD 1 XYes 2 No Director Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 241 Albermarle Street 21202 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1½∏Yes 2☐No IfYes, Give 152-154 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatic event, ITAL ONCE. Stone Mason Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giovanni Marsili . Maria Verdeccio ೭ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Marsili, Jr., son 1527 Martock La., Hanover, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entombment Lorraine Park 4/22/09 Baltimore, MD 21. Signature of Fureral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equence of) Examine that the death certificate be executed and -tran Due to (or as a consequence of) burial-P.O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) the 9 Unknown ģ signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 Hospital or Attending Physician: The certificate 1 □Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceri Name 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death P^{M} Phyllis G. Mevers 19, 2009 1:14 April 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖫 F 301-34-2335 70 Aug 18, 1938 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 W. Joppa Rd. 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Newell Goodman Edna Curry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Meyers, II/ Husband 1400 W. Joppa Rd. Towson, Md. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specif ntombment Druid Ridge Cemetery: 4-22-09 Pikesville, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fireral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ITH SEPTIC SHOCK disease or condition resulting in death) (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

> burial-transi and

attending physician for use as the buria

signed by the a

page 2 should peen

has

certificate

After this

I Director: /

Medical

Box 68760,

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Division of Vital Records,

Physician:

or Attending

death.

hours after No the within 24 hours are To the Funeral Dir To the Hospital

requires that the death certificate be

Physician

Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It e Marical Examiner must be radiiced at once.

/Medical

Director

Funeral

δ

Completed

Be (ပ

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

3 Suicide

29a. Certifie

4 Homicide

(Check only one)

29b. Signature and title of certifier

RENAL CELL CANCER Due to (or as a consequence of)

Examine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No Hospital: Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) Time of 28b. 1 Natural
2 ☐ Accident 5 Pending investigation

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Day

Year

Month

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 🗆 No 1 □Yes 2 LXN0 1 Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

eath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

6 ☐ Could not be

determined



09-03055	
Eugene Noyes	

igene Noyes	1- For State Contribution of Death											
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death 3. Time of Death									
ledical Exami		Eugene Noyes		Month April 16, 20	Day Year 109	2023 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De										
			Glen Burnie		Anne Arundel							
Funeral			If Under 1 Year If Under 24Hrs Months Days Hours Mir) Cc	thplace (State or Foreign ountry)						
Director		220-66-5180 1XM 2 F 54 Yrs.	World Bays Flours Will	07-31-1	1954	MD						
,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
ow any		MD Anne Arundel Glen Burn:				1 Yes 2X No						
yland 1-f sh	햦		10f. Zip Code	110	g. Citizen of What Cou							
the Maryland a or 28a-f show i	Director		21061									
ith th 123a notil		202 Ferndale Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	Decedent of Hispanic Origin? (S	pecify Yes or No-	U.S.A. 14. Race - American Indian, Black,							
items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes.	, specify Cuban, Mexican, Puerto		White, etc.							
fter d		1 Yes 2 No 3 Wildowed 4 Divorced If Yes, Give Year 1 Y	es 2 X No specify:		Specify: Wh	Specify: White						
ours a atura Kamir	d by		Usual Occupation (Give kind of t of working life. DO NOT use re		6b. Kind of Business/Industry							
6 172 h an "n EnlE	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		,160/	m . T 1							
withir in the reference.	шc		ry Worker	- (First Statute St	Tate Indu	stries						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) Eugene L. Noyes, Sr.	Evelyn	e (First, Middle, M Mae	Dietz							
212 uld be Ments mark	To B		Address (Street and Number or			e, Zip Code)						
MD d 2 sho lth and n 27 is sumati		Ms. Deborah G. Noyes / Sister 2997 Jo	essup Road Apt.	5 Jes	sup, MD 2	.0794						
		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition crematory or other		Date	20c. Location - City o	Town, State						
Baltimore, permit. Pages 1 an Department of Hea Important: If iter		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		23-2009	Brooklyn	Park, MD						
alti mit. I partm porta ury o		21 Signature of Funeral Service Licensee 22. Nar	me and Address of Facility 1 2	nd Ave S	SW Glen Bu	rnie, MD						
E.E.S.E O		Delina July M01479 Sing	gleton Funeral	& Cremat	ion Servic	es, P.A.						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death						
/Medical caminer		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease										
		or condition resulting in death) Due to (or as a consequence of):										
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. C. Due to (or as a consequence of):										
secuted secuted transit		events resulting in death) Last Due to (or as a consequence or): d.										
0, the executed sician and ourial - transi	dical	UNPENDED AMENDED										
	Ψ.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delive							
lox 6876(eath certificate s attending phyeror as the b	cian/M	past 12 months?	I death 3 Ectopic pregr er (Specify)	nancy	Month	Day Year						
Box e death c the atten ed for us		1 Yes 2 No 9 Unknown g Unknown	er (Specify)									
O. But the d	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?						
ires that the signed by	d by	Chronic Alcohol Abuse		1 Yes	2 No 3 Pro	bably 4 🗹 Unknown						
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tal Re(iian: The certificate	ပိ	25. Was case referred to medical	26.Place of Death (Chec									
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ing Ph After	n: T	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe h	now injury occurred							
ttend death. stor: y the f	atio	1 V Natural 5 Pending 2 Accident Investigation	1Yes 2No									
Division of Vital Records, P.O. Box 6876 (10 spital or Attending Physician: The law requires that the death certificate 24 hours after death. 24 hours after death. 25 hours after death. 26 hours by the attending physician by the attending physicially filled in by the funeral director, page 2 should be detached for use as the b	Certification:	3 Suicide 6 Could not be determined (Specify)	factory, office building, etc.	28f. Location (S or Town, S		tural Route Number, City						
Di Hospital 24 hours 2 Funeral	-(-)	stad										
the the	e(s) and manner as sta and place, and due to t	the cause(s)										
To Your	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)						
		When Brandl Mo	O.C.M.E.		April 17, 2009							
g_{μ}		30. Name and address of person who completed cause of death (Item 23a)			J							
\			enn Street, Baltimore, Mi	21201								
S Regis		31. Date filed (Month, Day, Year) Registrar's Signature.	,									
- Neg is	150	ADD 0 1 2000 A Market										

DHMH 17 Rev 1/2001 OCME 2006

OCM

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4/18/2009 Anne C. Neher 6:30 P M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3510 Sanguine Dr. New Windsor Carrol1 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea 9/7/1954 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours Min. 1 □ M 2 🖾 F Months Days 577-26-3944 54 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Carrol1 New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3510 Sanguine Dr. 21776 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 **K** No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Henry Neher Catherine Rita O, Neill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 Sanguine Dr., New Windsor, MD 21776 Mary Hughes/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/22/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Peter The Apostle Cem. Libertytown, MD 21. Signatury of Funeral Service deenses 22 Name and Address of Facility Burrier - Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1. Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can e or each line. Approximate Interval Between Onset and Death 23a Part 1 Im ediate ause (Final disea condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 1 uberculosis that initiated events resulting in death) Last IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 2 D No 1 ☐ Yes 25. Was case referre o medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

\$

Completed

Be

2

MD

ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be natified at

death with the Maryland

within 72 hours after

12 should be filed with and Mental Hygieu 7 is marked other the

permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked c any Injury or other traumatic.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by

Be

Medical Certification: To

and burial attending physician for use as the buria ģ signed | has page 2 s certificate director,

Hospital or Attending Physician: The law requires that the death certificate be executed

this After this funeral of

n 24 hours after death.

ie Funeral Director: A
oletely filled in by the fu

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completely

death.

Box 68760,

P.O.

Records,

Division of Vital

2 No

5 Pending

☐ Could not be

determined

1 ☐ Yes

27. Mann of Death

2 Accident

3 Suicide

4 ☐ Homicide

(Check only one)

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 \sum Nursing Home

28d. Describe how injury occurred

5 Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

6 ☐ Other (Specify)

29b. Signature and title

29d. Date signed (Month, Day, Year)

30. Name and address of death (Item 28a) (Type, Print)

31. Date filed (Month, Day, Year APR 21

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 4:21 P M Nadine Anita Owens April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Bel Air <u>Upper Chesapeake Medical Center</u> | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 12,1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) ial Security Number **Funeral** 1 □ M 2 X F Ohio 212-34-2244 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiens. In Department of Health and Mental Hygiens. In Tit it fem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II.* Medical Examinant outher traumatic event, II.* Medical Examinant outher traumatic and the statement of the stat 1 ☐ Yes 2 💢 No Director Pylesville Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2013 Channel Road 21132 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 21215-0036 1 ☐Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hance Curnutte Bessie Perry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Owens, Husband 2013 Channel Road Pylesville, Maryland 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/21/09 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY DISTRESS ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?) WEUS, Nadive Division of Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▶ No Was autopsy performed? 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title certifer 00056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DE 600 Upper Chesapeake Prive Bel Air, MD Jason Birnbaum, M.O. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 2 1 2009

-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 Betty M. Petr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Staalt Baltimort ranklin Saware 0 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2X) F Davs 212-26-2115 78 Director 06/14/1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at Baltimore Baltimore Director MD 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9728 Matzon Road 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No White Specify 2 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Lauterbach Gilbert Panuska ဂ 19a. Informant's Name/Relationship (Type. Print Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 78 North Prospect Avenue, Catonsville, MD Sandra Ziolkowski 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🛮 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/22/09 Parkwood Cemetery 4 ☐ Donation _ 5 ☐ Other (Specify) Parkville, MD 21. Sign are of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 234. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dis se or condition resulting in death) **Physician** meumothorax /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 No 2 🗹 No 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manurer of Death 1 Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of peg Square Drive Baltimore MD BINH

DHMH 17 Rev 1/2001

State Registrar

		-	State	aryland / Depa <i>Cer</i>	artment of H rtificate of L			ene . No. O O O O	10075			
			1. Decedent's Name (First, Middle, Last)				2. Date of Death	2003	3. Time of Death			
	Physicia /Medic		Clarence F. Patenaude	P	April 18,	Day 2009 Year	9:50 P M					
Way.	Examin		4a. Facility Name (If not institution, give street and number)		,	Location of Death		4c. County of Death				
g-F			Glen Burnie Health & Rehab		Glen Bu			Anne Arund				
П	Funeral Director		4 N 4 4 0 F	e (In yrs. last birthday) 76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Apr. 10;	(ear) 1933 Mass	lace (State or Foreign ltry) achusetts			
			Usual Residence of Decedent	, 0								
	ryland	_	10a. State 10b. County			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No					
	Ba-f s	Director	Maryland Anne Arundel	Glen Burni			100	(1)				
	with the		10e. Street and Number		10f. Zip Code			. Citizen of What Cour				
	eath ns 23	Funeral	8242 Great Bend Rd. 11. Marital Status 12. Was Decedent F	Ever in U.S. 13. V	21061 Was Decedent of Hi	ispanic Origin? (Sper n, Mexican, Puerto F		14. Race - Americ				
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N If Yes, Give 1 ☐ Year or Dates:	No 1	lfYes, specify Cuba 1 ∐Yes 2⊠ No	n', Mexican, Puerto F Specify:	Rican, etc.)	Black, White, o	etc. i ite			
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occupa	ation during most of workin		b. Kind of Business/Inc	dustry			
21	within 7 jene. r than "	mple	Elementary/Secondary (0-12) College (1-4or 5		Military							
2	e filed w al Hygie other tl vent, III	S	17. Father's Name (First, Middle, Last)	Career	Army	18. Mother's Name	(First, Middle, Ma					
ano	ould be f Mental I arked of atic eve) Be	(unknown)			(unknowr		,				
ary.	2 should be and Mental is marked aumatic ev	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	and Number or Rura	Route Number, 0	City or Town, State, Zip	Code)			
×	1 and 2. Health a em 27 is		Lynn C. Wallace / Daughter	8242	Great Ber	nd Rd., Gl	len Burni	ie, Marylan	d 21061			
Baltimore, Maryland	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other ODGs.		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, cren Glen Have			L 23,	c. Location - City or To Len Burnie,				
Balti	permit. Departn Importa any Inju		21. Signatur of Fun-val Section-License MD 222. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061									
68760,	Physician /Medical Examiner be executed it is the prival-transit at the prival-transit in the prival-transit i	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any, leading to immediate eause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
O. Box	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnanc	у		23d. Date of delive	ery Day Year			
s, P.	law requires that the as been signed by th 2 should be detache	by Pr										
ğ	w requires t s been signe should be o		(circino ma	56 Bl	adde	V	1 X Yes	1 X Yes 2 No 3 Probably 4 Unk				
of Vital Record	The ate h page	Completed										
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death						
	ding .r After funer	tion: To	1 ☐ Yes 2 ☒ No Prospital: 1 ☐ Inpatite 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Inpatite (Month, Da		of 28c. Injur Worl	v at 2	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
Division	ai or Attending s after death. Il Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of Injury	ury - At home, farm, str c. (Specify)	reet, factory, office	2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1⊠ Certifying Physiclan: To the best 2□ Medical Examiner: On the basis of and manner st.	of examination and/or in								
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	_	29c. Licens			d. Date signed (Month,				
			et with	Y)	_ D 515	96	A ₁	pril 20, 20)09			
	10 V		30. Name and address of person who completed cause of d K. Ambalavanar, M.D., 7845	Oakwood Ro	d., Glen	Burnie, M	21061					
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 1 2009 32. Registr	rar's Signature	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 16b per FH 8890 4/29/09 TT ment of Health and Mental Hygiene

			For State Registrar	PState of Wa		rtificate of		, 0	g. No. 2	12676				
	Physicia	an	1. Decedent's Name (First, Middle, Las.	t)			2. Date of Death Month	Day Year	3. Time of Death					
	/Medic		JAMES	RICHARD	PREVITI			April 1		11:35 P ^M				
	Examin	er	4a. Facility Name (If not institution, give				Location of Death	1	4c. County of Death					
\perp			Frederick Memori 5. Social Security Number 6. Se		.] (In yrs. last birthday)	Freder	ick I If Under 24 Hrs.	8. Date of Birth	Frederic					
	Funeral Director			X M 2□ F	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 19,	1926 PA	place (State or Foreign ntry)				
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits				
	Mary Fred	ţo	Maryland Freder	ick	Mt. Ai	iry				1 □Yes 2X No				
	h the	irec	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	•				
	th wit	Funeral Director	14516 Shirley B	ohn Road		21771		Į	Jnited Stat	es				
	r dea	ne	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White,					
36	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, It. Modical Examination indicates indiffed at		1 ☐ Never Married 🏋 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		1 □Yes 2 🗓 No	Specify:			hite				
9	"2 hou natura ichi E	Completed by	15. Decedent's Edi	ucation		dent's Usual Occup		kina 1		Kind of Business/Industry				
21	thin 7 ne. Ne.	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done on NOT use retired	1)		Klon O. Ro	_				
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and	be fill	Be	17. Father's Name (First, Middle, Last)					ne <i>(First, Middle, M</i>	*					
ž	c Me	၉	Samuel Previti Pauline Rita Previti On the Market State of Market State Stat											
<u>N</u>	and 2 should ealth and Mer n 27 is marke er traumatic		19a. Informant's Name/Relationship (Type. Print) Wife Charlotte Elizabeth Previti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14516 Shirley Bohn Road Mt. Airy, MD 21											
re,	es 1 and 2 and Pestrange of Health a fitem 27 is rother trau		20a. Method of Disposition		20b. Place of Dispo cemetery, cren				0c. Location - City or T	own, State				
Baltimore, Maryland 21215-0036	Page nent (ant: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify		008 Brentwood, MD									
Ba	permit. Departr Importa any Inja	į	21. Sig at a of Funeral Service Gense Burrier-Queen Funeral Home & Crematory, PA 1212 W Old Liberty Road Winfield, MD 21784											
		3	23a. Part 1. Enter the disealle, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between											
ind.	Physician		/mmediati Cause (Final disease r condition Conset and De											
hand	/Medical Examiner		resulting in death)	Due to (or as a	conse vence of):									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a										
	uted d insit	Examiner	cause (Disease or injury that initiated events											
oʻ	eath certificate be executed attending physician and for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a										
68760,	ate be nysicia ne bui	edical	(d										
	ing ph	Med	IF FEMALE:	-										
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					23d. Date of deliver Month					
P.0.	he de / the a ched f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown			monar Bay roa							
σ.	that the plant of	/ Ph	Part II. Other significant conditions co	23e. Did tob	e. Did tobacco use contribute to the cause of death?									
Vital Records,	e law requires that the de has been signed by the e 2 should be detached	ed by						1 □ Ye	s 2 □ No 3 □ Pro	bably 4 🔀 Unknown				
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œ —	The I	mo	W-1/2-1-1-1		autopsy perform	ned? death? ⊠No 1 □ Yes	ompletion of cause of 2 □ No							
ita	stan: ertific ctor. I	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one						
<u>></u>	hysle this o		1 ☐ Yes 2 📉 No		t 2 KER/Outpatier		4 Li Nursing H		nce 6 Other (Spec	ify)				
Division of	ding Physician: The In. After this certificate ha funeral director, page	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time of Injury	Wor	ork?							
isi	or Attencater death Director: I in by the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be						28f Location /Street and Number or Rumi Pouts Number					
<u>S</u>	al or A s after il Dire	Certification: To	4 Homicide determined	building, etc.		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical (examination and/or in				ause(s) and manner as ate and place, and due					
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Month	Day, Year)				
			▶ OMI tt			MD	H 405	39	Ands	0 2009				
	nxl		30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type,	Printy	H 405	1 . /	1					
1	4. 1		John Molswa	xth Y	00 W-	1111 5/.	Mede	PICICIC	MD 21	101				
	Sta Registra		31. Date filed (Month, Day, Year) ADR 9. 1 2009	32. Registrar	a Signature	وا								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State of Maryland / Depart State of Maryland / Depart Cert	tificate of L			eg. No:?	12677						
	Dhuaisia	_	Decedent's Name (First, Middle, Last)	1		2. Date of Death Month	16, 2009 ear	3. Time of Death						
	Physicia /Medic	al -	Cora V. Pend	April		12:15A M								
	Examin	er		4b. City, Town, or Be1	Location of Death		4c. County of Deat							
ar .			2511 Fairway Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		tholace (State or Foreign						
	Funeral Director		213-12-6979 1□ M 213 F 88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 4,	1921 Mar	yland						
	and w	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation				10d. Inside City Limits						
	Mary -f sho	to	Maryland Harford	Bel Aiı	•		1 □ Y							
	r 28a	Director	10e. Street and Number	10f. Zip Code		10	10g. Citizen of What Country?							
	h with	al D	2511 Fairway Drive		21015		United States							
	ems deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent	/as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White							
39	should be filed within 72 hours after death with the Maryland and Mental Hygiene. And Mental Hygiene. I marked other than "natural" or items 23a or 28a-f show umatic event, I're Medical Exeminar must be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	□Yes 2KINo			Specify:	White						
ŏ	2 hou	Completed		ent's Usual Occupa	ation during most of work		16b. Kind of Business	Industry						
27	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	9								
7	ed wi ygier yer th			memaker	18. Mother's Name	(First Middle A	Own Home							
ב	be fill ad oth even	Be	17. Father's Name (First, Middle, Last) John L. DeVaux			E. Walla								
څ	nould d Mei narke	P		n Address (Street				Zin Code)						
a Z	nd 2 st alth an 27 is r ir traur	1					te Number, City or Town, State, Zip Code) Air, Maryland 21015							
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State				20c. Location - City or							
Ti m	it. Pa rtmer rtant: njury			18/2009 Dundalk, Maryland										
Ba	Deparenti Deparenti Importanti any ir		21. Signature of Funda Pervice Librasee	Home of undalk,	Dundalk, I Maryland	nc 21222								
			23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Betwoen Consett and Description of the control of th											
	hysician / /Medical		disease or condition resulting in death) Due to (or as a consequence of):											
	Examiner		12											
	D .≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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Box	eath certi attending for use a		IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □		23d. Date of de									
B	requires that the death cer pen signed by the attendin hould be detached for use	Completed by Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of death 5 □ 9 □ Unknown		Month	Month Day Year								
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Division of Vital Records,	w requires that the de been signed by the should be detached	d by	atual filestate	I thattal										
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<u>=</u>	lan: prtifica	Be C	25. Was case referred to medical examiner?		26. Place of Deal									
<u></u>	Physician; this certific ral director,		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	it 3□DOA Oth	er: 4 Nursing H		ence 6 ☐Other (Spe	ecify)						
o uc	IIng P I. After t funera	ion:	27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe he	ow injury occurred							
<u>is</u>	or Attending after death. Director: After in by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	28f. Location (Street and Number or Rural Route Number,										
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i	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner stated.	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manner a date and place, and du	as stated. e to the cause(s)						
P	Fo the vithin 2	Mec	29b. Signature and title of certifier	29c. Licens	e number	2	29d. Date signed (Mon							
	. , , ,		Saw 50	D3.	2277		2009							
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	-									
			David S Dunn M.D. 615 West Micha 31. Date filed (Month, Day, Year) APR 2 1 2009 Channel S. Aparle	il Belm	1 mD 210	14								
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature											

				State of Maryland / Department of Health and Mental Hygiene 1 - State Reg. No. 2 1 0													1.0	C 7 0		
				Registrar 1. Decedent's Name	e (First, Middle	, Last)			061	incat	e or i	Jeani		2. Date of I	Death		لالا	3. Time	of Death	
pm		Physicia /Medic		JOSEPH	I.			PINE	S					APRTL	16	2009	Year	2:2	5Р м	
25 p	7	Examin		4a. Facility Name (/ ARDEN CO	URT OF	give street a	and number) VILLE			PΙ	KESV						TIMOF			
Ń		Funeral Director		5. Social Security N 217-12-7	049	6. Sex 1 X M 2		ge (In yrs. la 87	st birthday) Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	FEB 1	Birth Day, 1 ^V 6	122	9. Birthpi	lace (Stat	e or Foreign	
6	pue	ow #		Usual Residence of 10a. State	10b. County			10c. City,	Town or Lo	cation							10	Od. Inside	City Limits	
9)9	Mary	or 28a-f show	ctor	MD	N/A				BALTI	MORE					-,				es 2 No	
0)91140	5-0036 72 hours after death with the Maryland	ous aret bearn with the ways	Funeral Director	10e. Street and Number 1111 HAMLET HILL ROAD, #1212 10f. Zip Code 21210 10g. Citizen of What Cou											try?					
0	ar deat	Items 23a	unei	11. Marital Status		Ari	as Decedent med Forces?	•	. 13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Or an, Mexica	rigin? (Sp n, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - American Indian, Black, White, etc.				
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	Baltimore, Maryland 21215-0036	d d d	To Be C	17. Father's Name MORRIS	(First, Middle, L	Last)	PINES	;				18. Moth		e (First, Midd	e (First, Middle, Maiden Surname) BERNSTEIN					
oseph	Maryla	and z shou ealth and N n 27 is mai her traumai		19a Informant's N DAVID P	ame/Relationsh	nip <i>(Type. Pr.</i>) N	int)		19b. Maili 602	ng Address CRUM	s (Street CREE	and Numb K ROA	Per or Run AD ME	DIA,	nber, C PA 1	ity or Towr .9063	n, State, Zip	Code)		
6	more,	rages is ent of He nt: If item ry or othe			position Cremation 5 Other (S)		al from State	20b. Pla Ce BETH	ace of Disponentery, crea	osition (Na matory or 0 0H C0	me of other place NG .	ce)		Date / 2009	- 1		- City or To			
	Balti	epartm portal y Inju		21. Signature of Fu						2. Name a			30	L LEV						
	ш 8	20 E 8 9		23a. Part 1. Enter 1	the disease or	complication	is that cause	d the death						ROAD or respirator			ILLE,	MD 2 Approximately Approximately Approximately Approximately 2000 Appr		
4		hysician /Medical		shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final on	only one cau	Due to (or as	ine. EW	R	ody	-	1	me	tia		-		Onset ar	Between nd Death	
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	× 68	ding pt	/Med	IF FEMALE:	-	23c If	ves outcome	e of pregnar	ncv							024 D	ete of delive			
	D. Box 6	the attending productions to the control of the con	Physician/Me	23b. Was deceder in the past 12 1 Yes 2	nonths? □No	1 4	23c. If yes, outcome of pregnancy 1				23d. Date of delivery Month Day				Year					
	P.O.	signed by the a		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									ntribute to th	te to the cause of death?						
	rds	w requires s been sign should be	ed by	1 □ Yes										□Yes	2 Probably 4 ☐ Unknown					
	Division of Vital Records, P.O. Box 68760,	ate has be	Completed									aı	24a. Was an autopsy performed? 1 Yes 2 3 40. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 3 40.							
	/ital	certificate ector, pag	Be C	25. Was case reference	rred to medical	Ulasaia	-1.				104			th (Check on	ly one)			Λ	-T- 0	
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	ion	tending leath. tor: After the funer	ation	1 Natural 2 ☐ Accident	5 Pendin- investig	g jation	(Month, D	ay, Year)	Injury	М	28c. Injui Wor 1 □	ḱ? lYes 2.∐]No │							
	5	al or Alterno s after death Il Director: ed in by the i	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 □ Could r determ	not be ined 28	e. Place of In building, e	njury - At ho ttc. <i>(Specify</i>	me, farm, st	reet, factor	ry, office			28f. Locatio City or	n (Stree Town, S	et and Nun State)	nber or Rura	al Route N	lumber,	
(The Hospital	to the nospital of At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)	1 CertifyIn 2 Medical	Examiner: (n: To the bes On the basis and manner s	of examinat	wledge, dea tion and/or i	th occurre nvestigatio	d at the ti	me, date a	and place eath occu	, and due to rred at the tir	the cau ne, date	se(s) and react	manner as s e, and due to	stated. the caus	se(s)	
14	ام ا	vithin 2 To the I comple'	M	29b. Signature and	title of certifier	Ama	e /	Q	h sr	29	Oc. Licens	se number	27	40	29d	Date sign	ed (Month,	Day, Yea	" 2009	
				30 Name and add	ress of person	who comple	ted cause of		23a) Type	Print)	CIMPI	, ()	allei	, lor	d	lima	MUNA	MO	21092	

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G890 4/30/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month IL Day **Physician** 2889 07:50A M **ROMANS** WALTER ANDREW /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 1, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York **XX**M 2□ F 127-01-7048 93 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, It. My Jichl Exantment out the notified at 1√XYes 2□No Director Baltimore Maryland None the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 USA 5207 Purlington Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mys 2 □ NoWW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: USA ģ 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Golf Pro Country Club 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Adam Romans Unknown Dedek Ann ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21304 Zion Road Brookville Maryland 20833 19a. Informant's Name/Relationship (Type. Print) Son Walter Andrew Romans Jr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation 3 Removal from State St Mary's Ch Cemetery April 20,2009 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of FMITTCHELL-WIEDEFELD FUNERAL HOME INC 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** /Medical Due to (or as a consequence of):
ISCHEMIC CARDIOMYOFATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed CORONARY ARTERY DISEASE and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 ☐ Other (specify) ned by the a detached f ☐Yes 2☐No 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No. 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To after death. I Director: After the 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death. le Funeral Director: Apletely filled in by the fi 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ABDALLAH J.

31. Date filed (Month, Day, Year)

HELOU

2009

M. D.

32. Registrar's Signature

OSLER DRIVE

TOWSON, MARYLAND 21204

7601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 19,2009 **Physician** 11:44 A M Hubert Ruby Horst /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex 1016 Cherlyn Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Feb 26, 1934 Germany 75 Director 215 30 0551 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a fivedical Eva. if we must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 1016 Cherlyn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XYes 2 No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 □√ylo Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weber Freya Heinz Ruby ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1016 Cherlyn Road Essex Maryland 21221 Wanda Lee Ruby (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park 4/21/2009 Elkridge, Maryland 4 Donation 5 Sther (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Si a re of Funer Ser ice Licens 1407 Old Eastern Avenue Essex Maryland 21221 23a. F-rt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s oc or heart failure. List only one cause on each line. Onset and Death Immed ate Cause (Final disease or ondition resulting death) metastatic Physician 1 month ung cancer /Medical Due to (or as a consequence of): pulmonary disease Examiner hronic Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ibrillation. anasarca page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) соmpletely

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Chris

29c. License number

D0056316

Blvd, Baltimore,

29d. Date signed (Month, Day, Year)

200

and manner stated.

m.D.

1141

Pah.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ark

			For State of Maryland 1 - State Registrar	•	rtment of Health al tificate of Death	na wentai Hy	giene Reg. No:2	12681
			1. Decedent's Name (First, Middle, Last)			2. Date of De Month	ath Day Year	3. Time of Death
	Physicia /Medic		Thomas Ruark			April	15 2009	10 21 FM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of Dea	ath
- 2			708 Holly Avenue		Pasadena		Anne Ai	
	Funeral Director		5. Social Security Number 6. Sex 1 □ ★ 2 □ F 7. Age (In yrs. last 1 □ ★ 2 □ F 6. Sex 6. Sex 1 □ ★ 2 □ F		If Under 1 Year If Under 24 Months Days Hours	Min. (Month, Da	th 9. Bi ay, Year) C L4 1939	rthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation			10d. Inside City Limits
	sho	ē	Maryland Anne Arundel		Pasade	n a		1 □Yes 2 ⅓No
	the N	Director	10e. Street and Number		10f. Zip Code	lla	10g. Citizen of What C	ountry?
	with a or		708 Holly Avenue		2112	22	US	
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Was Decedent of Hispanic Original of the second of Hispanic Original of the second of			erican Indian,
21215-0036	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show Jicel Evaniments be notified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	f Yes, specify Cuban, Mexican, l □Yes 2☑No <i>Specify:</i>	Puerto Rican, etc.)		_{ite, etc.} White
Õ	2 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of	of working	16b. Kind of Business	s/Industry
21	iE " E €	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)	or working		
21		ا ا	12	<i>P</i>	Asset Manager			king
Maryland	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)		18. Mother	's Name (First, Middle	, Maiden Surname)	
√		မ	Garland A. Ruark		Lill		Metzler	
Jar			19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number			Zip Code)
	5 to 00 to		Merrill A. Ruark (spouse) 20a. Method of Disposition 20b. Pla		Holly Avenue, F	Pasadena, I	20c. Location - City o	r Town, State
Baltimore,	of fit		1 St Burlai 2 Li Cremation 3 Li Removal from State		l l	April 20	,	
Ē	permit. Pag Department Important: I any Injury o				dge Cemetery! 2. Name and Address of Facility	2009	Elkridge,	SERVICE STREET
Ba	permit. Departr Importa any Inja		21. Signature of Funct. Servic. Li enSee		3111 Mountain	Road, Pasa		1122
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as o	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician			nce	1			2 years
	/Medical Examiner		resulting in death) Due to (or *s a conseque	nce of):	V.	1 - 1		2.12.21
	Examine	<u>_</u>	Sequentially list conditions. b. Carchion	nyo	Jacob 18	homi		zgews.
	red isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	inceg gir):				
	xecur and al-trar	xan	that initiated events resulting in death) Last	ence of):				
68760,	cate be executed physician and the burial-transit							
687	E 0 2	ledical	u					
Вох	eath certific attending p	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		75		23d. Date of d	elivery
m	death e atte d for	Physician/M	in the past 12 months? 1		Ctopic pregnancy Other (specify)		Month	Day Year
P.0	that the de ned by the a detached t	hys	9 ☐ Unknown					
S, I	The law requires that the death cert ite has been signed by the attending age 2 should be detached for use a	by P	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause given in Part I.	_	tobacco use contribute	
of Vital Records	w require been si should b		Chonic renail Julius	=) t	Aparian 81	10	Yes 2 No 3 No	Probably 4 Unknown
ecc	e law re has be je 2 sho	Completed	Planel effison, Colo	n ce	incor	24a. Was		autopsy findings available ocompletion of cause of
œ _		E O				perf	ormed? death′ 2 No 1 □ Ye	?
ita	sian: ertific ctor,	Be (25. Was case referred to medical examiner?		26. Place	of Death (Check only		
<u></u>	Ğ .g. ₹	2	1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatier		rsing Home 5 Res	idence 6 ☐ Other (S _k	pecify)
	ding Ph h. After th funeral	on:	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Work?		how injury occurred	
sio	e at at a	cati	2 Accident investigation		M 1 □Yes 2 □N			
Division	or Attending after death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		(Street and Number or wn, State)	Rural Route Number,
			29a. Certifier 1. Certifying Physician: To the best of my know	ladas dact	h occurred at the time, date	d place, and due to th	e cause(s) and manner	as stated
	Hospital 24 hours a Funeral stely filled	Medical	(Check only one) Medical Examiner: On the basis of examination one) and manner stated.	on and/or in	n occurred at the time, date and ivestigation, in my opinion, deat	th occurred at the time	, date and place, and d	ue to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and the of pertifier		29c. License number	-	29d. Date signed (Mo	nth, Day, Year)
	F S F Ö		Attending Phys	ncian	D4497	73	April 1	6 2009
7	1.45		30. Name and address of person who completed cause I death Mem	23a) (Type.	Print) 328 HOSPIT	ALDRIV	E, SUITE	202
7	TTV		GURMEET - S. SAWHVEY MD	, (-) = -)	Print) 328 HOSPIT GLENBUR	NEE MO	21076.	
25.	Sta	ite	31. Date filed (Month, Day, Year) 2. Registrar's Signatu	ire				
	Registi	ar	APR 2.1 2009 Parker A.	MAR	Red			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 20, 2009 5:50 AM April Lottie Isabelle Rohde /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium Stella Maris Hospice 8. Date of Birth (Month, Day, Year)
Sept. 28,1911 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min 1 □ M 2X F 97 Maryland Director 213-38-5736 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 18a of 18a 1 ☐ Yes 2X No Director MD Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21093 USA 121 Greenmeadow Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. <u></u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home/ Education Homemaker/Teacher 12 N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Marshall Herbert Bowen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Timonium, MD 21093 121 Greenmeadow Dr. Charles A. Rohde/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition Pages April 25, 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 21. Signature of Funda Serv Inc. J. Flagle Approximate Interval Between 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □ Yes 2 No 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\tau \) Nursing Home \(5 \) Residence \(6 \)Other (Specify) \(\text{HOSPICE} \) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 X Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Check only

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Nurse Practitionness estated. 29d. Date ≢igned (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

5:50 a.m.

I SABELLE ROHDE

DHMH 17 Rev 1/2001

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

			For State Registrar	State of Maryland		artment of F			íene _{eg. No.} 2 N N C	12603
	Physicia		Decedent's Name (First, Middle, Last)	Mary Elias				2. Date of Deat Month April 1	h	3. Time of Death 1:11 A M
	/Medic Examin		4a. Facility Name (If not institution, give str 5809 Stuart Avenue			4b. City, Town, o Baltimo	r Location of Death Ore		4c. County of Deal	th
	Funeral Director		703 00 00 00	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, April 4	9. Bir 1904 NJ	thplace (State or Foreign ountry)
	Maryland -f show ied at	tor	Usual Residence of Decedent 10a. State	10c. City,	Town or Lo	cation Balt	timore			10d. Inside City Limits XXYes 2 □ No
	with the I 3a or 28a	al Director	10e. Street and Number 5809 Stuart Avenue			10f. Zip Code 212	215	l l	0g. Citizen of What Co	Duntry?
036	urs after deatt al", or items 2	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Vidowed 4 ☐ Divorced	. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of H If Yes, specify Cub. 1 □Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work		16b. Kind of Business, Elementa	·
land ?	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last)	Frank Elias			18. Mother's Name Susanna		Maiden Surname)	
, Mary	es 1 and 2 should b of Health and Ment f item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type Richard Rogers (Sc				and Number or Rui Avenue B		; City or Town, State, . 21215	Zip Code)
more	Pages 1 ament of He ant; If item		20a. Method of Disposition 1 ☐ Burial 2 ∰ remation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	l ca	ace of Dispo metery, crer antic	esition (Name of matory or other place Crematory	^{ce)} 4/18		20c. Location - City or Glen Burni	
Balt	permit. Pages D-partment of Important: If is any injury or		21. Signature of Funeral Service Licensee	ant					Home Inc.	
8760,	ficate be executed Medical Examiner s the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to form as a conse	ence of): ence of): ence of):	er the mode of dyil mc thor ia	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death L Wee Wee
O. Box 6	ath certi attending for use a	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t. If yes, outcome of pregnar 1	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of de Month	livery D <i>a</i> y Year
σ.	w requires that the de sbeen signed by the should be detached t		Part II. Other significant conditions control	ibuting to death but not resul	iting in the u	nderlying cause giv	ven in Part I.	23e. Did tot	oacco use contribute to	o the cause of death? robably 4 Unknown
al Records,	: The law requ cate has been , page 2 should	Completed by						24a. Was a autops perforr 1 □Yes	ned? death?	utopsy findings available completion of cause of s 2 □No
<u>₹</u>	/sician: The s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ E		nt 3 🗆 DOA Otr	26. Place of Deat		e) ence 6 □Other <i>(Spe</i>	ecify)
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, is	Certification: To	27. Manne of Death 1		28b. Time o Injury	f 28c. Inju Wor			ow injury occurred	
Divis	ipital or Attendours after deathours after deatheral Director: , filled in by the f	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, f <i>a</i> rm, str)	reet, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital within 24 hours and To the Funeral completely filled	Medical		cian: To the best of my known: On the basis of examination and manner stated.		vestigation, in my	opinion, death occur	rred at the time, d	late and place, and du	e to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier Fo Jelfod	o MD		29c. Licens	フマノチ		9d. Date signed (Mon 4/16/200	
	25 V	8	30. Name and address of person who com	FLOADO		Print) 705	DIGITA	NO NO	0 2109	0
ľ	Sta Registr		31. Date PR 2 1 2009 /	32. Registrar' Signati	tak	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:07a M Mary L. Reynolds April 18 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Stella MAris Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan . 8 , 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. Months 1 □ M 2 □ F 84 450-30-6083 Texas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Middle River 1 ☐ Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7341 21220 USA Green Bank Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ KNo If Yes, Give Year or Dates: Specify Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leona M. Brown Hester Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7341 Green Bank Road Baltimore MD 21220 Sherman C. Nichols /son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Glenn Cemetery 4/25/09 Reading MA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 MAce Ave Balto. Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ease. Enter Uncerthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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Completed

Be

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the Maryland

death with

9:07

2009

permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" not item any Injury or other traumatic answer.

Hospital or Attending Physician: The law requires that the death certificate be executed

physician and s the burial-tran burial-trar ending p atten for ur signed by the a been si has page 2 cer ificate this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760,

REYNOLDS

Exami Physician/Medical \$ Completed Be Certification: To

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2X No 9 Unknowr

> 2 Accident 3 ☐ Suicide

4 Homicide

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

24a. Was an autopsy perfori 2X No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Date of Injury (Month, Day, Year) 27. Manner of Death 1X Natural 5 Pending

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only oneX Nurse Practitioner stated.

29b. Signature and title of certifie

investigation

6 Could not be determined

30. Name and ad ress of pers in who completed cause of death (Item 23a) (Type, Print)

CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKIE JONES,

State Registrar

6/

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** vanda Dri 200 /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1700p, to Hopkins Tonns 8. Date of Birth July 21,1954 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 218-62-3576 54 Director Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD n/a Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 1755 Abbotston St. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:Black 2 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dept.Social Service permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumants. Elementary/Secondary (0-12) College (1-4or 5+) Finance Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Smith Charles Jackson ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaGary Williamson (son) 1755 Abbotston St. Balto,Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 AOther (Specify) GUSO RU Baltimore RM 22. Name and Address of Facility Calvin B. Scr Signature of Funeral Service Licensee Scruggs Funeral Home 1412 E Preston St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HUPERTENSION PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 1 🗆 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

MD

21213

Day

2 X No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Year

Approximate Interval Between Onset and Death

UPPM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Maryes 2 □ No

Division of Vital 24 hours after deatl Funeral Director: within 2.

filled in by

Medical

State Registrar 3 Suicide

29a. Certifier

31. Date file

4 Homicide

29b. Signature and title of certi

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2009 Month **Physician** 13:15 PM RYAN LEWIS April /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City
If Under 1 Year If Under 24 Hrs. Sinai Hospital of Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 73 06/02/1935 558-46-7940 Director OH Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, its Medical Examination in the confidence 1 ☐Yes 2 No **Funeral Director** BALTIMORE MD OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 825 QUEENS PARK DRIVE 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No WHITE Specify. Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) COUNSELOR DIVISION OF CORRECTIONS 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be (17. Father's Name (First, Middle, Last) 7 is marked traumatic e GRANT RYAN BESSIE ပ္ ERVIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health
Important: If item 27 i
any injury or other tra
once. 825 QUEENS PARK DRIVE, OWINGS MILLS, MD PAMALA RYAN / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 04/20/2009 4 Donation 5 Dother (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mart 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) the 9 Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☑No 24a. Was an autopsy performed? 1 □ Yes 2 □ No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 Veena RES-000 17 pri) 18 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Teena Sandeep ,M;D 31. Date filed (Month, Day, Year) 32. Registrar's agnature State Registrar

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Constance Schomann 2009 12687 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Constance Voelker Schomann Physician/ April 16, 2009 Month 1142 hrs **Medical Examiner** Constance Jeanne Schomann 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Harford **Bel Air** 900 Martell Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland Days Min. Months Hours \$ept. 1, 1954 Director XX_{F} 54 216-66-8475 1 M Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 3nv Yes 2 X No Bel Air 28a-f show Maryland HArford 23a or 28a-f show notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21015 900 Martell Court Unit F 苬 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funera 11. Marital Status or items must be White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: White If Yes, Give Year Yes 2 X No specify: Widowed 4 X Divorced Examiner "natural" ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 inent of Health and Mental Hygiene ant: If item 27 is marked other than " Medical MD 21215-0036 Healthcare Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, the John George Voelker Patricia Ann Boyle Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Heather Drevna Alexandria, Virginia 22302 Daughter 3205 Ravensworth Place 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, April 19 other Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel rent or rent or v or o Forest Hill, MD 2009 Donation 5 Other Specify Bel Air of Funeral Service Licensee 21. Signati, 22 Vans funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. Enter the disease, or complicate Physician Between Onset and failure. List only one cause on each /Medical Death Amerosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi death certificate be executed nysician/Medical AMENDED #1 per ME g891 5/8/09 TT 5/12/09 Jh #10e Per FH G891 ling physician as the burial -UNPENDED Item#19a.perFH.G891 5/8/09 Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth Fetal death use Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown g Unknown the The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. þ Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? page Yes 2 V No Yes 2 Nο Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? Hospital: 1 Residence 6 V Other: Scene DOA Nursing Home 5 this Inpatient 2 ER/Outpatient ို 1 ✓ Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: ✓ Natural Yes 2 d in by the f Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 17, 2009 O.C.M.E. Grasse (

State Registrar 32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

CCME

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 2688 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death APRTL **Physician** 2009 9:40 A M HERMAN SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours 1 XM 2 ☐ F 216-18-3501 Jan.30,1924 Director 85 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at Director Harford 1 ☐ Yes 2 No MD Fallston Pages 1 and 2 should be filed within 72 hours after death with the 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3323 Charles Street 21047 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 14. Race - American Indian. Black, White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: white ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aide Edgewood Arsenal 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Arthur Smith, Sr Helen Plaeser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. June Smith-spouse 3323 Charles Street-Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highview Memorial 4-20-09
Gardens 20c. Location - City or Town, State 20a. Method of Disposition p Burial 2 ☐ Cremation 3 ☐ Removal from State Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8800 Harford Road Parkville, MD 21234 EVANS FUNERAL AND CREMATION 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician coron disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an autopsy performed? certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No iours after death neral Director; / filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe Apr: 117,200 D3227 x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MACPHAIL ROAD 21014 BEL AIR, MD. 31. Date filed (Month, Day, Year) State APR 2 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Bernard Schorr 2009 Charles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 17. Age (In vis. last high/hope) Battimore N/A If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1ADM 2□F Months Days Hours AUG 26 1948 60 212-52-1093 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at Baltimore N/A MD Completed by Funeral Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 810 S. Grundy Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 🏋 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Campus Police Officer Higher Education 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Item 27 is marked ot any lijury or other traumatic even ang. pe Anna D. Raab Joseph Schorr Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3218 Guilford Avenue, Baltimore, MD 21218 Virginia Lee Hagee – ex-wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 04/20/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service neme: Williams 22. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Examiner Subdural Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ACCIDENTAL the Hospital or Attending Physician: The law requires that the death certificate be execute the burial-trai attending physici**a**n and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregna Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Certimeneder disense 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 2 🗆 No 1 □ Yes 2 **M**No 1 □Yes neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1⊠Yes 2 No 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DQA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation APAIL 14, 2009 WARDY M 1 D

28e. Place of hiury - At home, farm, street, factory, office building, etc. (Specify) Probable Fell 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 21224 HOME 810 S. GIRUNDY BACTIMOE, MD within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier RES- 000 APAL 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

EASTERN AVENUE BALTIMORE,

4940

32. Registrar's Signature

100 CHHAR

31. Date filed (Month, Day, Year)

Mb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Mary Catherine Sprecher 4:48 AM APRIL 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST AGNES HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1□ M 2 F Months Days Hours 137-03-8035 91 JUL 31 1917 Ohio Director Usual Residence of Decedent flled within 72 hours after death with the Maryland I Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Neglect Exp. of set must be redfled at 1 □Yes 2 No Catonsville Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA Rolling Road 401 S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 □Yes 2XNo Baltimore, Maryland 21215-0036 Yes. Give Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit, Pages 1 and 2 should be a Department of Health and Mental Important: If item 27 is marked or Beulah Anna Cavey Pinkney Pollard Vitus ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 401 S. Rolling Road, Catonsville, MD Robert Sprecher - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or Metro Crematory, Inc.04/20/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Licensee Williams Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS FEW DAYS /Medical Due to (or as a consequence of): Examiner URINARY FEW DAYS TRACT INFECTION Sequentially list conditions, it any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, the attending physician by Physician/Medical the as IF FEMALE: use ves, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy for Month Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 ⊠ No Vital Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled i 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical

within 2 To the I

MARY

RECHER

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State

Registrar

RAHUL JAIN 31. Date filed (Month, Day, Year) APR 2 1 2009

29b. Signature and title of certifier

900 CATON AVENUE 32. Registrar's Signature

and manner stated.

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

29c. License number

68254

29d. Date signed (Month, Day, Year)

APRIL 20 2009

	1	For State Registrar	ne (First, Middle	e, Last)				Ce	rtificate of	Dear	th	2. Date of De	Reg. N	10.2U	09	_	of Death
hysician /Medical		PHYLL				S						April			2009	11:	:00 pM
Examiner		4a. Facility Name (130 Laure		_					4b. City, Town, a	r Locatio	on of Death			c. County Anne			
uneral rector	1	5. Social Security N 181-26-46	Number	6. Sex		7. Age	(In yrs. la	ast birthday) Yrs.		If Und	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da Aug 29	th ay, Yea		9. Birth	hplace (Sta untry) nnsylv	te or Foreig 7ania
wow		Usual Residence o 10a. State	of Decedent 10b. County			1	10c. City,	Town or Lo	ocation							10d. Inside	City Limits
Ba-f si	5	MD	Anne	Arui	ndel		Lau	rel								1 □ Y	es 2 No
Dire	5	10e. Street and Nu		m	-1 D-	_			10f. Zip Code				-	Citizen of V		untry?	
ed other than "natural", or items 23a or 28a-f show event, the Medical Exercitive must be notified at Re-Completed by Fundral Director		130 Laure 11. Marital Status 1 □ Never Mari		Ţ	12. Was Dece Armed For 1 □Yes	edent Ev		. 13.	2072 Was Decedent of H If Yes, specify Cub		Origin? (Spe ican, Puerto F	cify Yes or No Rican, etc.)				rican Indian e, etc.	,
tural", o	2	3 ☐ Widowed			If Yes, Giv Year or Da	ve			1 □ Yes 2√2√No dent's Usual Occup	Spec	cify:		16h	Specify Kind of Bu	Whi		
is marked other than "nature aumatic event, the Medical E	in pier	(Spe Elementary/Seco Grade 12	cify only highe.	st grade	College (1	-4or 5+)		(Give life. Gro	kind of work done DO NOT use retire	during n d)	most of workin	g				ed Hor	se Ra
a other event, the		17. Father's Name		Last)				- 010		18. Mo	other's Name	(First, Middle				<u> </u>	DC TO
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is mai		19a. Informant's N		hip (Typ	oe. Print)		JI,	l	ng Address (Street							(ip Code	
other traumatic	- 1-	Jorge Sol		spo	ouse		001 5		Laurel ra					· ·		20724	
int in ite		20a. Method of Dis 1 ঐ Burial 2 4 □ Donation			emoval from S	State	1		osition (Name of matory or other plan 1 Cemete:		4/15/	ate 2009			-	Town, State arylar	
Important; If item 27 is any injury or other tra once.		21. Signature of F	uneral Service	1 Infise		M007	70	2	Name and Addre Donaldsor 313 Talbo	ss of Fa	ncility neral	Home,	P.A			=======================================	
	+	23a. Part 1. Enter	the disease, or	complic					ter the mode of dyl					rary	Tanc	Approxir Interval	nate
ician		Immediate Cause disease or condition	(Final	drily on				ythmi								Onset a	nd Death
dical		resulting in death)) ()	r a			conseque								_		
niner	.	Sequentially list co	onditions,	b				Disea	se								
nsit		cause. Enter Unde Cause (Disease or that initiated event	erlying r injury	₹	Due to (or as a	conseque	ence of									
pnysician and stressit stressit burial-transit polical Examiner		that initiated event resulting in death)	s Last	С	Due to (or as a	conseque	ence of):						•			
		IE EEMALE:		d	•												
to the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t Medical Certification: To Be Completed by Physician/Medical Certification:	y Storian in	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months? ∰No	23	3c. If yes, out 1 ☐ Live b 4 ☐ Pregr 9 ☐ Unkno	oirth 2 nant at ti	☐ Fetal	death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	у				23d. Dat Mo	te of deli inth	ivery Day	Year
and be deta	2	Part II. Other signi	ificant condition	ons con	tributing to de	eath but	not resul	ting in the u	nderlying cause giv	en in Pa	art I.					the cause	
page 2 should									_				psy rmed?	I	orior to c death?	topsy findin	
ector, p	,	25. Was case referexaminer?	rred to medical	Į.						26. Pl	lace of Death	1 □Yes (Check only o		ΧO	i 🗆 tes	2 13/13/0	
funeral director, page	2	1 Yes 2 ∑ 27. Manner of Dea 1 XXX tural	th 5 Pendin	l g	28a. Date of			R/Outpatie 28b. Time o Injury	Wor	y at k?	2	ne 5 XX esi 8d. Describe			``	cify)	
al Director; After led in by the funeral Certification:		2 Accident 3 Suicide 4 Homicide	investiç 6	not be	28e. Place buildir	of Injury ng, etc.	/ - At hon (Specify)	ne, farm, st	M	Yes 2		8f. Location (a City or To	Street a	and Numb ite)	er or Ru	iral Route N	lumber,
mpletely filled	- 1	29a. Certifier (Check only one)				asis of e	xaminati		h occurred at the ti								e(s)
compl		29b. Signature and	title of certifie	//	The man				29c. Licens	e numb	er		29d. E	Date signed	d (Month	n, Day, Year	-)
(2)	4	30. Name and add	m nel	1	den		U C	222) (Time		688	0		Apı	cil 1	0, 2	2009	
	3	Harry M.	Marris	, M.	D. 30	00 A	rmor	y Pla	ce, Suite	3C	, Bal	tímore	, Maı	rylan	d 2	21201	
State legistrar		31. Date filed (Mon	nin, Day, Year) 9 1 200 0	a .	32. Re	egistrar'	s signatu	barke	1								

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:30 A M 2009 19 ALEXANDER SMITH, JR. APRIL WILLIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HYATTSVILLE PRINCE GEORGE'S SAINT THOMAS MORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NC 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1**X** M 2□ F Yrs APRIL 1, 1927 Director 82 245**-**20**-**6631 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ?? is marked other than "natural", or items 23a or 28a-f show fraumatic event, the Modest Even, increment to multified at 1X Yes 2 □ No Director CAPITOL HEIGHTS MD PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 Funeral 412 MILLWOOF DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify ð BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "r any fijury or other traumatic event, it Item 27 app figure. Elementary/Secondary (0-12) College (1-4or 5+) LERNER'S RETAIL MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALICE MACON WILLIE ALEXANDER SMITH, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11005 TRAFTON CT KETTERING, MD 20774 DORIS SMITH-HALL / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-24-2009 BRENTWOOD, MD 4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 21. Signature Funeral Service Licensee 22. Name and Address of Facility MARSHALL 'S FUNERAL HOME OF MD SUITLAND, MD 20746 DEREK E. SLOCUM 4308 SUITLAND ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Zweeks InTracevebral e mmorhape /Medical Due to (or as a consequence of) **Examiner** Auterioschenotic Candiovascula RDistan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ eter une 4itus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 101852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ICENSBURG Rd Hyattso: 4 e MJ 2075 423 NU 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Harold William Schafer 2009 3:20 A M April 18, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Days Months 15☑ M 2 ☐ F 215-12-3265 81 Mar. 14, 1928 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 ☐ Yes 2 XNo Maryland Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2902 Brightwater Lane 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Automotive Technician Auto Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Joseph Schafer Mary Elizabeth Wiker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene B. Schafer / Wife 2902 Brightwater Lane, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, Maryland 4□Donation 5 Nother (Specify)EntombmentBe1 Air Memorial Gdn. 4-23-09 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE ESPIRATORY -DAXS disease or condition resulting in death) Due to (or as a consequence of): OBSTRUCTIVE PULMONARY DISEASE MRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinational Learciffied and once.

Baltimore, Maryland 21215-0036

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Box 68760

P.O.

Records,

Division of Vital

Pages 1

sician and burial-transit signed by the attending physician I be detached for use as the burial cate has been si page 2 should b

Examine Physician/Medical ੬ Completed certificate Be Certification: To funeral of or Attending Fafter death.

IF FFMALE

23b. Was decedent pregnant

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No

3 Suicide

4 - Homicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

nesapeake arive Bel Air, Mo

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

and manner stated.

DHMH 17 Rev 1/2001

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State Registrar

completely filled in by the

Medical

To the Hospital or within 24 hours at To the Funeral D

		,	FOR	partment of Health and l		ene g. No. 2 11 11 9	12691
	Physicia	an	Decedent's Name (First, Middle, Last) Alice Cecelia Sullivan		2. Date of Death Month	Day Year	3. Time of Death 4:38 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		19 , 2009 4c. County of Death	1
	Examin	ei	1026 Woodshire Lane	Street		Har	ford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		154-16-9817		Oct. 10,	1920 New	Jersey
	/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	a-fst	ctor	Maryland Harford Street			_	1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
	sath w	Funeral	1026 Woodshire Lane 11 Marital Status 12. Was Decedent Ever in U.S.	21154 3. Was Decedent of Hispanic Origin? (S		USA 14. Race - Amer	ican Indian
0	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If time x7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Inc. Medical Evan har must be notified at once.		1 Never Married 2 Married 1 XYes 2 No	if Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White,	
2	ural", c	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 █ No Specify:	· · · · · · · · · · · · · · · · · · ·		hite
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7	ould b Ment marked artic e	은	Daniel (nmn) Cummins		n) McAlee		
	12 sh th and 7 is m traum			ailing Address (Street and Number or Ru			
ב ע	tem 2			26 Woodshire La., S sposition (Name of crematory or other place)		Oc. Location - City or T	
	Pages nent o nt: If i		Atlanti		2-09	ell Manor,	NT
<u> </u>	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	22 Name and Address of Facility MCCOMAS FUNERAL H	iome, P.A.	CII PAUOI	IND
0	로스트 # 의		Ally M'Comos Kent	1317 Cokesbury Ro	ad, Abing	don, Maryl	
			23a. Part1. Ente(t)le disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	1 4 0 11		st,	Approximate Interval Between Onset and Death
	hysician /Medical		immediate cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	heart tailur	e		1 year.
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	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				20.
)	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or a la consequence of):	SION			de jears.
8 .	cate be executed physician and the burial-transit	dical E	L _d				
9	ng phy as th	Medi	IF FEMALE:				
Š,	ath ce ittendi or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliver Month	very Day Year
5	y the a	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
Ĺ	s that ined b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	en sig		Ny parlipidemia		1 ☐ Yes	s 2No 3□ Pro	bably 4 Unknown
<u>.</u>	law r has be	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
ָם י	r: Ine licate r, pag				perform 1 □ Yes 2		2 □No
=	sicial s certif irecto	Be	25. Was case referred to medical examiner? 1 Yes 2 10 40 Hospital: 1 Inpatient 2 ER/Outpa	Other:	ath (Check only one	nce 6 ☐ Other <i>(Sp</i> ec	W.A.
5 7	g Pny ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe hov	1-7	ny)
<u>5</u>	endin sath. or: Aff he fur	atio	2 Accident investigation	M 1 Yes 2 No			
<u> </u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the hospital or Attending Prysician: The law requires that the death certificating 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, described in the passis of examination and/cone) Medical Examiner: On the basis of examination and/cone)				
:	vithin : To the ::omple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	(Day, Year)
	,		Linde a walk MI	D 34208		4/20/	2009
7	241		30. Name and address of person who completed cause of death (Item 23a) (Ty		11/2 1	10 000	210 04
	Sta	te.	GINDA A. WAUSH MD 37/8 Norris 31. Date filed (Month; Day Year) - 32 Aggistrar's Signature	villerd, SoiteC, Vo	urrettsvill	e my	× 087 (
	Registra		100 0 1 2000 A	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year -09 **Physician** earin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Tm If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛛 F Months Days Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at md Ves 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 2 102 Funeral death v 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married or, Baltimore, Maryland 21215-0036 Specify: þ ac 3 ☐ Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) edu'a the 12-th marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h ean ပ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) d'austre Department of Health al Important; If item 27 is any injury or other trau once. 1624 00 100 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Daurial 2 □ Cremation 3 ☐ Removal from State Kandaelstown 5 ☐ Other (Specify) 4 Donation Servive Lice 21. Signatur Funer salto, md. Approximate Interval Between Onset and Death 23a. Part 1 ver red disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, or heart failure. List only one cause on each line. Immediate ause (Final disease frondition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, n any, leading to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a nonsequence of: Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C To the Hospital tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

29c. License number

PAUT PL.

D47934

29d. Date signed (Month, Day, Year)

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		-	For State Registrar	State of Ma	ryland	-	artment of H <i>rtificate of L</i>			giene Reg. No.2	000	1260	5
	_		Registrar Decedent's Name (First, Middle, Las	t)		001	timeate of t	Journ	2. Date of Dea	ath	003	3. Time of Death	<u>U</u>
A	Physicia /Medic	an al	CAROLE			SC	HERR	La serios of Donah	APRIL		Year 2009 unty of Death	7:00 A	М
7	Examin	er	4a. Facility Name (If not institution, give JEWISH CONVALESO		NG HUI	МЕ	4b. City, Town, or BALT 1		ı		BALTIMO	RF	
gard.	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. las		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt			place (State or Forei	gn
	Director		219-30-19//	□M 2 💢 F	75	Yrs.	Months Days	Hours Will.	8. Date of Birt	1934		MD MD	
	land w t	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					I 0d. Inside City Limi	ts
	Many i-f sho fied a	ţo	MD BALTIMO)RE	1	BALTI	MORE					1 □ Yes 2 💢 N	lo
	n 28a n noti	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?	
	23a c ust be		8221 SCOTTS LEVE	L ROAD			2120			US			
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2(X) Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No	Ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		Race - Americ Black, White, pecify: WH	etc.	
5-0	72 hc "natu dical	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual Occup kind of work done	durina most of wor	rking	16b. Kind	of Business/In	dustry	
121	within ene. than " he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retired	•		RF#	AL ESTA	TF	
d 2	filed Hygie other ent, th		17. Father's Name (First, Middle, Last)				00111121121		ne (First, Middle,				
lan	should be ind Mental marked o matic eve	To Be	HARRY		GORN			BELL	.E		BAC	KMAN	
Maryland	2 should and Men is marke aumatic	Π	19a. Informant's Name/Relationship (7				ng Address (Street				•		
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		DONALD SCHERR /	HUSBAND	DOS DIS		1 SCOTTS	LEVEL RO	DAD, BAL		tion - City or T	21208	
Baltimore,	Pages nent o ant: If I		20a. Method of Disposition 1	1)	MOS	ESTANO DMOOR	nsition (Name of NTP FTORE) HEBREW Name and Addre	04/2	20/2009 SOL LEVII	BA	ALTIMOR	E, MD	
Ва	permit. Departr Imports any inj		21. Signature of Fulleyar Gervico-Lider	20								MD 21208	}
			23a. Part1. Enter the disease, or companion, or heart failure. List only	olications that caused	the death.	Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	
E	Physician /Medical examiner		Immediate Cause (Final disease or condition resulting in death)		BROV	ASCU ince of):	ILAR A	-CCI DE	NT		- 1	Onset and Death	
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	nce of):							
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
60,	ficate be executed physician and sthe burial-transit	EX	resulting in death) Last	Due to (or as	a conseque	ence of):							
68760,	icate physi	dici		.d		-							
P.O. Box (Physician: The law requires that the death certific this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal c	eath 3	⊒Ectopic pregnanc; ⊒ Other (s <i>pecify)</i> _	y		230	d. Date of deliv Month	rery Day Year	
	res that igned by be deta	by Ph	Part II. Other significant conditions of		ut not result	ing in the u	ınderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	
ıd	w require been sig should b	ed b	HYPERTEN.	SION					1 🗆	Yes 2DH	No 3□ Pro	bably 4 Unknow	٧n
Vital Records,	sician: The law ra certificate has be irector, page 2 shc	Completed	DIABETES								24b. Were aut prior to co death? 1 ∐ Yes	opsy findings availal ompletion of cause o 2 No	ole of
/ita	ctor, I	Be C	25. Was case referred to medical examiner?						ath (Check only o	one)			
or/	Physic this cral dire	유	1 Tes 2 10 No	Hospital: 1 Inpatie		R/Outpatie		4 Mursing I	Home 5 ☐ Resi 28d. Describe			ify)	
n	Ing After	ioi	27. Manner of Death 1	(Month, Day		Injury	Woi	rk? Yes 2 □ No	200. Describe	now injury o	occurred		
Division	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At hom c. (Specify)	ne, farm, st	reet, factory, office		28f. Location (City or To	Street and I wn, State)	Number or Rui	ral Route Number,	
Ri	To the Hospital or within 24 hours after To the Funeral Dirtompletely filled in it	Medical C		ysician: To the best miner: On the basis o and manner sta	f examination					date and p	lace, and due	to the cause(s)	
/	To ti	Σ	29b. Signature and title of certifier				29c. Licens				signed (Month		
Ì			bluron H.					63327		APRI	218,	2009	
			30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,	Print)	51150 0	OF AUG	DA	T1000	Ench 20	110
	St	ate	31. Date filed (Month, Day, Year)	37. Registr	ar's Signa	ure	TUINDO	LUCHE	LL ITVE	> 17/12	-1114016	-11ND 40	<u>~</u>
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			The state of the s										

The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, the Hospital or Attending within 24 hours after death. **To the Funeral Director:** ^A

28a-f show

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ca

UMM, 201 Gast university Tarkway Registrar's Signature 31. Date filed (Month, Day, Year) Lever B. Jak **ORIGINAL**

ABDEL RAHMAN M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ft Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AT243 8346

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Dennis vance S		1- For State Registrar	e of Maryland /		cate of D		na ivientai		Reg.	No.	200	9 269 3. Time of Death
Physici Medical Exami		Decedent's Name (First, Middle,La	DENNIS VAI	NCE SMIT	H, JR.			N/)ay)9	Year	1842 hrs
		4a. Facility Name (if not institution, g	ive street and number)				r Location of D		· · · · · ·	4c. Cc	ounty of Death	
Funeral		456 Man O War Court 5. Social Security Number 6.5	Sex 7. Age	(in yrs. last bi		nnapolis f Under 1 Ye	ar If Under 24	4Hrs. 8.	Date of Birth		e Arundel	nplace (State or Foreign
Director		218-33-4558	X M 2 F	17		Months Da		1.6	ct. 16,		Cou	Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
Aaryland 28a-f show 1. at once.	ō	Maryland Anne Ar	undel				apolis					1 Yes 2 X No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho atic event, the Medical Examiner must be notified at once.	I Director	10e. Street and Number 456 Man 0	'War Court				21409			USA	of What Coun	
eath wit items 2 ust be r	Funeral	11. Marital Status1 X Never Married 2 Marrie			13. Was D If Yes,	ecedent of H specify Cuba	ispanic Origin? an, Mexican, Pu	' (Specify ierto Rica	Yes or No- n, etc.)	14.	Race - Americ White, etc.	an Indian, Black,
after de al", or ner mu	by Fu	3 Widowed 4 Divorce	1 Yes 2 If Yes, Give Year or Dates:	X No	1 Ye	s 2 X N	o specify:			Spe	ecify: Wh	uite
hours 'natur	ed b	15. Decedent's Education (Specify					ation (Give kind e. DO NOT use		done 1	6b. Kind	of Business/Ir	System System
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5		r. @ Bro	adneck	Sr. High	Schoo	o1	Anne	e Arundel	. Co. School
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Las	·				18.Mother's N				name)	
2121: uld be fil Mental I marked	To Be	19a. Informant's Name/Relationship	nce Smith, Sr (Type, Print)		9b. Mailing Ad	ldress (Stre	eet and Number		Ann Bar		or Town, State,	Zip Code)
2 0 4 4 1		Marsha Tonarelli	(Moth	ŕ			ree Drive					
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Species 			of Disposition atory or other Haven Me			Da 4/20/0			ation - City or T Burnie,	Town, State Maryland
Baltin permit. I Departm Imports	7	21. Signature of Funeral Service Lice	ensee Kevin E E	cker	22. Nam 320	e and Addres	ss of Facility I	McCull Pasac	ly-Polyn dena, Md	iak F • 21	uneral H 122	lome, P.A.
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on		the death. Do	not enter the r	node of dying	g, such as card	iac or res	piratory arres	t, shock,	or heart	Approximate Interval Between Onset and
/Medical 'xaminer	ı	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		f Head							Death
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	nine	if any, leading to immediate	Due to (or as a conse	quence of):								
outed A	Examiner	events resulting in death) Last	Due to (or as a conse	quence of):								
68760, certificate be executed and ing physician and isses as the burial - transit	Medical	UNPENDED	AMENDED									
8760, ificate be ag physici		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnanc	y 2 Fetal	death 3	Ectopic pr	egnancy			ate of delivery	ay Year
Box 6876(death certificate the attending phy.ed for use as the b	Physician/I	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at	time of death	-	(Specify)		-5				,
ed the	Phy	Part II. Other significant conditions	a Olikilowii	but not result	ing in the und	erlying cause	given in Part I		23e. Did toba	acco use	contribute to t	the cause of death?
, P.O. ires that the signed by be detack	d by							_	1 Yes	2 🗸 N	lo 3 Prob	ably 4 Unknown
of Vital Records, ing Physician: The law requir Miter this certificate has been someral director, page 2 should the second that the second of	Completed							_ i	24a. Was an autopsy	/	prior to c	topsy findings available ompletion of cause of
Reco	m o								perform 1 Yes 2		death? 1 ✔ Ye	s 2 No
Vital Recysician: The his certificate director, page	a	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	-+ 0 FD/	Outpatient 3		Other N	neck only lursing Ho			e 6 🗸 Other	Coope
n of Vital ing Physician: After this certif funeral director,	۴ ا	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b	. Time of Inju		jury at Work?	28d	. Describe ho	w injury		. Scelle
ion fendi eath.	atior	1 Natural 5 Pending 2 Accident Investiga	FOUND: Day, Yeation Apr 15, 2009		OUND: 38 hrs	_1_	Yes 2 V No	Sub	oject shot	self		
Division pital or Attendion ours after death. teral Director: Affilled in by the fi	Certification	3 ✓ Suicide 6 Could no determin	ot be 28e. Place of Inj	ury - At home, gle Family		actory, office	building, etc.		or Tour Sto	10+	Number or Rui Annapolis, N	ral Route Number, City MD
To the Hospital within 24 hours Fo the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 W Medical Examin	cian: To the best of my er: On the basis of exan and manner stated.									
7 5 8 5 8	Me	29b. Signature and title of certifier	and married stated.				nse number				e signed (Mor	nth, Day, Year)
		11111	1	//	13	0.0	C.M.E.			April 1	6, 2009	
		30. Name and address of person who Russell Alexander MD.	Assistant Medic	al Examine	r 111 P		t, Baltimore	e, MD 2	1201			
Si Regis	tate trar	31. Date filed (Monta PR 2 1	2009 32. Registrar	's Signature	par	Kal						
-										ME		

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Jean Thieblot 16 11:00AM April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death **Examiner** 1508 Park Ave. Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 7, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours New Jersev 214-32-8214 1933 76 April Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. and the first 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, it a Penic Exeminar interests to the grammatic event, it as the first sing in the second and a second a second and a second and a second a se 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland N/A 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 Park Ave. 21217 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**XX**No <u>≽</u> Specify Specify: 3 Widowed 4 Divorced white Year or Dates: 1955-57 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) attorney private practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Armand Jean Thieblot Eva Pasquelina Mancini ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suzanna C. Thieblot/wife 1508 Park Ave. Baltimore, MD 21217 Baltimore, Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Green Mount Crematory Apr. 18,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2 Name and Address of Facility Ltchell-Wiedefeld Funeral Home, Inc. 200 York Rd. Baltimore, MD 21212 John O. Mitche 6500 York Rd. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to r as a r nsequence of): resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 Who 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Towson MM 31. Date filed (Mohrn, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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of Vital Records,

Division

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			for State Registrar	olalo ol mai,		ertificati				-	Reg. No.	2009	9 12	700
		e ·	Decedent's Name (First, Middle, Last))						2. Date of De	ath Day	Year	3. Time	of Death
	Physicia /Medic		Anne Mary Jaskini	ia Tallaric	0					April	19,	2009	1:45	5 p M
ĵ	Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	f Death			County of Dea		
	The second second second		Laurel Regional F		n um lant hirthda		irel	If Under 2	24 Hrs	8 Date of Bir		rince (o or Foreign
	Funeral Director			M 2 🔀 F	n yrs. last birthda 78 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 2			thplace (State ountry) TX	e or Foreign
١.			Usual Residence of Decedent							oune 2	.0,19	30		
	irylan ihow 1 at	_	10a. State 10b. County		c. City, Town or	Location							10d. Inside	City Limits es 2 ₹No
	8a-f s	Director	MD Prince 0	George	Laurel	1404 =	0.1				10- 04	an of Mhat Co	L	2 140
	with the	Ē	10e. Street and Number 9262- #44 Cherry I	.ane		10f. Zip	0708				USA	en of What Co	ounity?	
	i be filed within 72 hours after death with the Maryland nial Hygiene. ed other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at	Funeral		12. Was Decedent Eve	r in U.S. 1:			ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Ame		
٥	or iter niner		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give		If Yes, spec			, Puerto	Hican, etc.)		Black, Whit	e, etc. nite	
25	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								ореспу.		
9500-61212	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. De	cedent's Usua ve kind of wor e. DO NOT us	ai Occupa rk done c	ation during most	of worki	ng	16b. Kir 	d of Business	/Industry	
7	e filed within 72 h al Hygiene. I other than "natu vent, the Medica	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		se Owne		7			Tho	roughbi	ced Rac	cina
	i filed I Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle				<u> </u>
lan I	uld be Aental rked o tic eve	To B	John Frank Jaskir	nia				Eme]	lia 1	Moczyge	emba			
Maryland	nd 2 should I Ith and Men 27 Is marker traumatic	-	19a. Informant's Name/Relationship (Ty		- 1	•				al Route Numb			Zip Code)	
	s 1 and if Health item 27 other tr		Frederick A. Talla							Laurel		ation - City or	Town Chata	
Baltimore,	0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	removal from State	20b. Place of Dis			, -	Apri.	1 22,		•		
Ё	it. Pa urtmer urtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	!	Holy Red				20	09 naldsor		imore,		7\
g	permit. Pag Department Important: I any injury o		Q Ke. SV. Q		1053					naluso: Laurel,			me, P	· A ·
	-		23a. Rart1. Enter the disease, or complishock, or heart failure. List only o										Approxim	nate
ų.	Physician		Immediate Cause (Final disease or condition	ne cause on each line.	Scao								Onset an	nd Death
,	/Medical		resulting in death)	a Due to (or as a c	onsequance of):									
	Examiner	_	Sequentially list conditions,	b	who	13)							, -	
	Jei Jisi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or):								Į,	
8	be executed ician and burial-transi	Exan	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):									
209/	eath certificate be executed attending physician and for use as the burial-transi	cal		d										
9	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	/ledi	IF FEMALE:					-						
ROX	ath ce ttendii	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐Live birth 2 [Fetal death	3 □Ectopic p		/			2	3d. Date of de Month	livery Day	Year
	at the dea by the ai	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death	5 Other (sp	pecify)						,	
J.	that the		Part II. Other significant conditions co	ntributing to death but r	not resulting in the	underlying c	ause give	en in Part I.		23e. Did	tobacco u	se contribute t	o the cause o	of death?
Records,	w requires that s been signed b should be deta	d by								1 🗆	Yes 2	No 3□P	robably 41	Unknown
S	aw rec	Completed								24a. Was		24b. Were a	utopsy finding	gs available
¥	The la	omp								auto perfe 1∐ Yes	psy ormed? 2[☑ No	death?	completion of s 2 ☑ No	it cause of
Vita	slan: artifica ctor, p	Be C	25. Was case referred to medical examiner?						of Death	(Check only			**	
Ž	hysic his ce	70	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpat			4 🗆 INUI	$\overline{}$	me 5□Res			ecify)	
n O	ding Physician: The lav n. After this certificate has funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injur		28c. Injur Worl	yat k? Yes 2∐1		28d. Describe	how injury	occurred		
Division or	I or Attend after death, Director: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury	- At home, farm,			162 Z 🔲 I		28f. Location (Street and	d Number or R	ural Route N	lumber.
<u>></u>	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,	,,			City or To	wn, State			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illed in by the funeral director, to completely illed in by the funeral director, to the funeral director, the funeral director, the funeral director is the funeral director.			vsician: To the best of r										20(0)
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exam	iner: On the basis of ex and manner state					ith occur	red at the time				
	with To t	Σ	29b. Signature and title of certifier			29		e number			29d. Dat	e signed (Mon	th, Day, Year	r)
	ہے		IND IND				NO	0677	L)	د	41	1767		
	1,0		30. Name and address of person who c		h (Item 23a) (Tyr) West 7		eet.	Fred	eric	k, MD :	21701			
	Sta	ite	31. Date filed (Month, Day, Year)		Signature			1100		,				
	Regist		APR 2 1 2009	Clever	a. par	Car								

			State of Maryland / Dep		Mental Hygi	ene
			1 - State Co	ertificate of Death	Re	g. No. 2009 12701
П	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year
	/Medic		Mary Helen Porcher Tucker			.6, 2009 1:30 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death Harford
_	Francis		2103 Williams Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Havre de Grace If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	
Н	Funeral Director		096-20-4026 1□M 2⊠F 83 Yrs.	Months Days Hours Min.	Mar. 29,	1926 Maryland
	P .		Usual Residence of Decedent			
	arylar show	_	10a. State 10b. County 10c. City, Town or	_ocation		10d. Inside City Limits 1 ☐ Yes 2 XNo
	18a-f	Director	-	le Grace 10f. Zip Code	1.0	g. Citizen of What Country?
	a or a		10e. Street and Number	·		
	ns 23	Funeral	2103 Williams Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	21078 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - American Indian,
(0	riten ir	Ψ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
<u> </u>	ral", o	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 No Specify:		Specify: Black
2-0	72 hc	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of wor		6b. Kind of Business/Industry
2	/ithin ine. han "	d m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Public Education
D D	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Exantral must be notified at		12 17. Father's Name (First, Middle, Last)		ne (First, Middle, M	
an	ould be filed v Mental Hygie arked other i atic event, tr	To Be	Theodore Edward Peters	_	Irene Gi	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evantinar must be notified at	ř		iling Address (Street and Number or Ru		
	1 and 2 Health a em 27 is		Melvin M. Tucker / Husband 210	3 Williams Drive,	Havre de	Grace, MD 21078
ore			20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)		0c. Location - City or Town, State
altimore,	Pages ment of ant; If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford	Memorial Gdn. 4-2	24-09	Aberdeen, Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Sign ture of Funeral Sentice Aicensee	22. Name and Address of Facility McComas Funeral Ho 1317 Cokesbury Rd	ome, P.A. , Abingd	on, MD 21009
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or head failure. List only one cause on each line.			
ζ,	Physician		Immediate Cause (Final disease or condition	ration		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	4.17		2 ~~
	Examiner	<u>.</u>	Sequentially list conditions, b.	morrium		Z W V V
	ted nsit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	entres		7/5 ym.
<u>ρ</u> ,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last c	, , , , , , , , , , , , , , , , , , , 		
8760	icate be executed physician and the burial-transit	dicall	d			
မ	rtifica ng ph as th	0	IF FEMALE:			
Box	The law requires that the death certific attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	B ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
O.	the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	i ☐ Other (specify)		Month Day real
0.	that the ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
Records,	w requires that the d been signed by the should be detached	Completed by	Ca Colon.		1 □ Ye	s 2 1 4 Unknown
S	w requirements	ete			24a. Was an	24b. Were autopsy findings available
	he lav te has	duc			autopsy perform	prior to completion of cause of death?
Vital	an: T	Be C	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ath (Check only one	1 ☐ Yes 2 ☐ No
	Physiclan: The la r this certificate ha ral director, page?		examiner? 1 Yes 2 No	ent 3 DOA Other: 4 Nursing H	lome 5 Reside	nce 6 Other (Specify)
0	De de	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year)	Work?	28d. Describe how	w injury occurred
Sio	tendi eath. tor: A the fu	cati	2 Accident investigation	M 1 □Yes 2 □No		
Division of	or Attending Physiclan: after death. Director: After this certific in by the funeral director;	Certification: To	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Rural Route Number, State)
_	spital ours a neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	e, and due to the ca	use(s) and manner as stated.
	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	urred at the time, da	ite and place, and due to the cause(s)
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
			I William MD	D32609.		+117109.
	20		30. Name and address of person who completed cause of death (Item 23a) (Typ			am mo
	V	to.	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	e Grace. n	W 210	78
	Sta Registr			land 1		

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of M	laryland .		rtment of F tificate of I	leaith and M Death		iene _{eg. No.} 20	09	12702
		Decedent's Name (First, Middle,	Last)					2. Date of Dear	th	V	3. Time of Death
Physici /Medi		Lewis Francis	Thomas					4/16/	2009	Year	3:45 P M
Examir		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, or	Location of Death		4c. County		
en L		CarrollHospice 5. Social Security Number			11:11:1-1	Westmi If Under 1 Year		0 D-44 Di-46		rroll	lane (Otata a Final
Funeral Director		220-70-3281	6. Sex 7. A	ge (In yrs. last 51	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 5/13/	Yea <i>r)</i> 1957	Coun	place (State or Foreign try) D.C.
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lor	eation					0d. Inside City Limits
Maryla f sho	ō		11		v Wind						1 □Yes 2KNo
r 28a	irec	MD Carr 10e. Street and Number	.011	New	A MIII	10f. Zip Code		1	0g. Citizen of	What Coun	itry?
th with	aD	3638 Frankliny	ville Rd.			21776)			USA	
partition is in the Marylating ALA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Evaminer must be notified at once.	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, e	
Jual", or i	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes 2 X If Yes, Give Year or Dates:		1	□Yes 2 X No	Specify:		Specif	y: Wh	ite
2 hou		15. Decedent's	Education		l6a. Deced	ent's Usual Occup	ation	- 1	16b. Kind of B		_
thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or	5+)	(Give i life. E	kind of work done on NOT use retired	during most of worki f)				
led wi Hygier Her th	ខ្ល	11			-	Carpenter	18. Mother's Name				Contractor
all be fill her orthand her or	Be	17. Father's Name (First, Middle, L Charles B. Tho	Ť					0. Ochs		,	
aryid should and Men s marke umatic	유	19a. Informant's Name/Relationshi			19b. Mailin	a Address (Street	and Number or Rura				Code)
and 2 s and 2 s ealth au n 27 is	١,	Gloria O. Thom	, , , ,				nville Rd			•	,
ss 1 a of Hei	1 3	20a. Method of Disposition		20b. Place		sition (Name of natory or other place			20c. Location		
Pages nent of land ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		∍	-	k Cemeter	· .	/2009	Washing	gton,	D.C.
Daltillo permit. Pages Department of Important: If II any injury or o		21. Signatur of up ral Service L	icensee				ieen Facili Fune				
		fung) cui	-146-1-46-6			ld Liberty			d, MD	21784 Approximate
	0 h	23a. P rt1. Inter the disease, or of hock, or heart failure. List of the limited limited in the limited limited in the limited	nly one cause on each l	in P	no not ente	me w		or respiratory arr	est,	2	Interval Between Onset and Death
Physician /Medical		dis ase r condition resulting in death)	a. Due to (or as		20000	revi				250	415
Examiner				s aconsequen	neta	(LANC					ireo L
D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequen	ue ut).						,
ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
ficate be executed physician and the burial-transit	a E	resulting in death) Last	Due to (or as	s a consequen	ice of);						
ficate phys the	edical		d								
onding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1=			, 23d. Da	ate of delive	ery
es that the death certification of the detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 ☐ Fetal de at time of deat		Ectopic pregnancy Other <i>(specify)</i>	у		Mo	onth	Day Year
at the	Phys	9 Unknown						- Distant		A-11	
Physician. The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	þ	Part II. Other significant condition	is contributing to death I	but not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did tol			ne cause of death?
w requir	etec				-			24a. Was a			psy findings available
he law te has age 2 s	Completed							autops perforr	med?	prior to cor death?	mpletion of cause of
vician: The certificate rector, pag	a	25. Was case referred to medical					26. Place of Death	1 🗆 Yes		1 Yes	PIL.
nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	tient 2 ☐ ER	/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 Reside	ence 6 Oth	ne (Specify	y)
770 (D) (D)		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, D.		b. Time of Injury	28c. Injury Work		28d. Describe ho	ow injury occur	red	
ttend death stor: /	icati	Accident investigated investigated a G ⊆ Could not coul	t he	At homo	form atra		Yes 2□No	20f Location (C	han a to a sa of \$1, one to	ha a a a Duan	I Davida Musebas
affer of Direct of in by	ertification:	4 ☐ Homicide determin	builing, e	etc. (Specify)	, iaiii, sue	et, factory, office		City or Towl	n, State)	per or Hura	l Route Number,
ospita hours uneral	cal C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the besi	t of my knowle	edge, death	occurred at the tir	me, date and place,	and due to the o	ause(s) and m	anner as s	tated.
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one) 29b. Signature and title of certifier	and manner s	stated.			e number		9d. Date signe		
6 ≥ 6 8		23B, digital and the greenmen	/			06	1303)	4/17	ina	say, roary
1. 1		30. Name and address of person w	o completed cause of	death (Item 23	Ba) (Type, F	Print)	Coshi	1,180	11/11	1150	
Sta	ite	3. Date filed (Month, bal), Year)	332. Regist	th CE	Wa.	- 51 100t	WOM	in some	MOQ	1101	
Registr		APR 2 1 20	09 Senga	J. J.	gar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 30 per DVR G890 4/21/09 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CE PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospita Baltimore er 1 Year | If Under 24 Hrs n/a

9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 □ F Months Min. 108 24 8147 76 21,1933 Jan. New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Ferns Way 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes **X**☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married **X**□ No 1 ∐Yes 2½∏No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School Masters Degree Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Robinson Mattie Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Kent Tolbert (husband) 25 Ferns Way Balto, Co., Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Apr.23,2009 Balto.Co, Md. 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Mature of Funeral Service Licenses Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final (andiae disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ■ No Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No Renal 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienimportant: if item 27 is marked other tha any injury or other traumatic event, the answer once. **Physician** /Medical Examiner Examiner

Physician /Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the "nected Eventing must be notified at

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria the detached cate has been signed by page 2 should be detach certificate I funeral director, this After t

Physician/Medical

Completed by

Be

Certification: To

the

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

within 24 hours after death To the Funeral Director: filled in by ō To the Hospital

completely

State Registrar

7 mouna us 29c. License number

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

125075

april 14, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Metropolitan Medical Associates 5601 Loch Raven Blvd. Balto. Md 21239

Marra 31. Date filed (Month, Day, Year)

(Check only one)

APR 21 2009



		1 - State of Maryland State of Maryland		artment of H		d Me		iene eg. No. 200	19 12701
Physici	an	Decedent's Name (First, Middle, Last)				2.	Date of Deat		3. Time of Death
/Medic	cal	Mildred A. Toms 4a. Facility Name (If not institution, give street and number)						2009	8:30 a ^M
Examin	ner	6208 Walther Ave.		4b. City, Town, or	imore			4c. County of D	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24	Hrs. 8.	Date of Birth	Year)	Birthplace (State or Foreign Country)
Director		218 12-2442 1 M 2 F 87	Yrs.	World Days	1,00.0	P	Apr.14		Maryland
yland now			, Town or Lo	cation					10d. Inside City Limits
n the Maryland rr 28a-f show	ctor	MD n/a	Ва	ltimore	City				1 □ Yes 2 □ No X
with th	Dire	10e. Street and Number 6208 Walther Ave.		10f. Zip Code	21006		1	0g. Citizen of What	Country?
Z1Z15-UU36 I within 72 hours after death with the Maryland giene. Ir than "natural", or items 23a or 28a-f show the Medical Evaninar rust be notified at the Medical Evaninar rust be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S	S. 13.1		21206	? (Specif	v Yes or No-	USA 14. Bace - A	American Indian,
after o		1 Never Married 2 Married Forces? 1 Yes 2 No If Yes, Give X		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2€ No	n, Mexican, Pi Specify:	uerto Ric	an, etc.)	Black, W	/hite, etc.
5-UU36 72 hours aff natural", or	ed by	Year or Dates:						Specify: b	
in 72 ni "nal	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give life, I	dent's Usual Occupa kind of work done d DO NOT use retired,	ation luring most of	working		16b. Kind of Busine	:ss/Industry
d Z1Z15- filled within 72 Hygiene. other than "nal ent, in e Medic	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Sel	f Employ	yed			Bar Own	er
	Be	17. Father's Name (First, Middle, Last) George Hill						faiden Surname)	
Tarylar Tarylar Should be and Menta is marked raumatic ev	2	19a. Informant's Name/Relationship (Type, Print)	10b Mailir	as Addrona (Street s			lliam	S , City or Town, Stat	to Zin Codo)
and 2 sh and 2 sh ealth an n 27 is r er traur		71 1 · · · · · · · · · · · · · · ·	dson		Walth		_		
9 - ∓ 5 ₹		20a. Method of Disposition 20b. Pl		sition (Name of natory or other place	e) :	Date	AVE.	20c. Location - City	Md. 21206 or Town, State
Saltimor Dermit, Pages Department of mportant: if it any injury or o		4 Donation 5 Other (Specify)	rison	n Forest	Ap	ril	28,2	009 Owi	ngsMills,Md
baltimol permit. Pages Department of Important: If it any Injury or once.		2) Aignature of Funeral Service Licensee	22	Name and Addres Calvin E	s of Facility B. Scr	ugg	s Fun	eral Hor	ne
		23a. Part 1. Enter the disease, or complications that caused the death		1412 E.	Prest	on	St. B	alto Md	• Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Noc	It fail	10				Interval Between Onset and Death
/Medical		resulting in death) a. Due to (or s a consequ		· · · · · · · · · · · · · · · · · · ·	00				1994
Examiner	<u>۱</u>	Sequentially list conditions, b. Due to for see a concessure.	cone office						
uted d ansit	Examine	fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	erree ory:						
e exec	Еха	resulting in death) Last	ence of):						
icate be executed physician and the burial-transit	dical	d							
box o	/Me	IF FEMALE: 23c. If yes, outcome of pregnant	ncv					and Date of	d-Program
death death d for u	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	′			23d. Date of Month	Day Year
at the lby the stacke	hys	9 ☐ Unknown				T			
ires th	þ	Part II. Other significant conditions contributing to death but not resu	iting in the un	nderlying cause give	en in Part I.				e to the cause of death? Probably 4. Unknown
law requires as been sign	Completed					_			·
he lav te has	Jup					-	24a. Was ar autops perforn	y prior ned? death	
clan: T	e e	25. Was case referred to medical			26. Place of	Death (C		!	∕es 2 □No
Physic Physic This ce	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Othe	r: 4 ☐ Nursin	ng Home	5 Reside	nce 6 Other (S	Specify)
nding F tth.	ion:	1 Natural 5 Pending (Month, Day, Year)	28b. Time of Injury	Work	rat ? /es 2 □ No	28d	. Describe ho	w injury occurred	
Atten r deat ector: by the	ifical	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, stre		res 2 🗆 110	28f.	Location (St	reet and Number or	r Rural Route Number,
tal or safte	Certification: T	4 Homicide determined building, etc. (Specify)				City or Town	, State)	,
To the Hospital or Attending Physician: The law requires that the death certificating 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	vledge, death ion and/or inv	occurred at the time vestigation, in my op	ne, date and pointion, death o	lace, and	due to the ca at the time, da	ause(s) and manne ate and place, and d	r as stated. due to the cause(s)
To th vithir To th comp	Me	29b. Signature and title of certifier		29c. License	number		25	9d. Date signed (Mo	onth, Day, Year)
		· Clesel tes n	OI	265	5-00	00	A	PRIL 2	0, 2009
2		30. Name and address of person who completed cause of death (Item							
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	Balt	move mi	> 2129	87			
Registra		31. Date filed (Month, Day, Year) APR 2 1 2009 Senting 32. Registrar's Signate	parke						

			For State	State of Maryland		rtment of H				
			Registrar 1. Decedent's Name (First, Middle, Last,)		imouto or E		2. Date of Death	2003	3. Time of Death
٠	Physici /Medic		Deborah Winch	ester Veverka					Day Year), 2009	8:00 A.M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Baltimo:			4c. County of Death	
	Funeral		108 Taplow Road 5. Social Security Number 6. Sec	x 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
	Director		103-44-2001]M 2½[F	54 Yrs.	Months Days	Hours Min.	June 18,		York
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation			11	0d. Inside City Limits
	a-f sh	ctor	Maryland N/A		Baltin	more City				1 X Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Medical Exeminar must be notified at once.	Funeral Director	10e. Street and Number 108 'Taplow Road			10f. Zip Code 2121	2	10g.	Citizen of What Coun United Sta	ates
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	_l Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - America Black, White, e	an Indian,
21215-0036	ours afte ral", or it Examin		1 ☐ Never Married	1		□Yes 2⊡No	Specify:		Specify:	white
15-("natu	Completed by	15. Decedent's Edu (Specify only highest grad	cation 'e co <i>mpleted</i>)	16a. Deced	ent's Usual Occupa kind of work done d OO NOT use retired,	ation Juring most of work	ing 16t	o. Kind of Business/Inc	lustry
212	withii giene. r than	omo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	me. L	Finance			T. Rowe Pi	rice
nd	oe filectal Hyg	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Mai	,	
ryla	d Meni d Meni narke	ို	Paul Winche					na Manning	1	
Baltimore, Maryland	nd 2 sh alth an 27 is r r traur	1	19a. Informant's Name/Relationship (Ty Mr. Gary P. Vev	- 1					ity or Town, State, Zip Maryland	
ore,	es 1 and 2 and 2 of Health a fitem 27 is		20a. Method of Disposition	con	ce of Dispos	sition (Name of place	-1		. Location - City or To	wn, State
Ĕ	Pag tment tant: I jury o		1 ☐ Burial 2XD Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	- Cha		- Bel Air	200	$\begin{bmatrix} 21, \\ 9 \end{bmatrix}$ For	orest Hill	, Maryland
Bal	permii Depar Impor any in	; ;	21. Signature of Firm ral Service Licens		22	Name and Addres ACEFUL AL 2325 YO	s of Facility ternative rk Road	es Funeral Timonium,	l &Cremation	on Ctr.,P.A 21093
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. ne cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Breast Co	arice	_				Tuears
	Examiner		f f	Due to (or as a consequen	nce of):					
	p ii	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequer	nce of):				15	
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):					
68760,	icate be executed physician and s the burial-transit	edical E		4						
			IE EEMALE.							
Вох	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d	eath 3	Ectopic pregnancy			23d. Date of delive	ry Day Year
0	that the de ned by the a detached f	ysic	1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ath 5□	Other (specify)			Worki	Day Tou.
ď.	res that signed b be deta	by Pr	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ord	w require s been sig should b							1 🗆 Yes	2 No 3 Prob	ably 4 🗌 Unknown
Records,	e law i has b	Completed						24a. Was an autopsy	prior to cor	osy findings available npletion of cause of
Vital	n: Th		25. Was case referred to medical					performed		2 □No
<u> </u>	hysician: The la his certificate ha I director, page 2	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient	t 3 □ DOA Othe	r-	h <i>(Check only one)</i> ome 5 Aesidenc	e 6 ☐ Other (Specify	()
Division of	ng Ph kiter th ineral	L:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury	28c. Injury Work	at	28d. Describe how i		/
sio	ttendi death. stor: A r the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	380 Blood of Injury. At hom	a form atra		'es 2□No	Opt Leasting (Ot-		
<u>></u>	al or A after I Direc d in by	Certification: To	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, iarm, sue	et, ractory, office		City or Town, S	t and Number or Rura tate)	Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	edical C	29a. Certifier (Check only one)	sician: To the best of my knowle ner: On the basis of examinatio	edge, death n and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as si and place, and due to	tated. the cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d.	Date signed (Month, I	Day, Year)
	- > F O		W. Omada V	(it	~ MC	0 036	986	Δ	0001 21	2000
	1	Ì	30. Name and address of person who co				0.0	0 4	ville MV	51
	l √	20		NS MO	107	13 tall	s Rd	Luther	villemy	21093
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 1 2009	32. Hegistrar's Signatur	por					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2009 Maria Viera Angel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Loch Raven Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🔀 F Director 467-25-5667 78 Dec. 17.1930 Texas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XNo Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with itent of Health and Mental Hygiene.
ant: If the male 7 is marked other than "natural;" or items 23a or :
any or other traumatic event, the Medical Examiner must be not a constitute over the Medical Examiner must be not a constitute over the Medical Examiner must be not a constitute over the male must be not a constitute over the Medical Examiner must be not a constitute over the male must be not a constitute over the male must be not a constitute over the male must be not a constitute or an account of the male must be not a constitute or an account of the male must be not a constitute or an account of the male must be not a constitute or an account of the male must be not a constitute or a cons 5819 Westwood Avenue 21206 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ♥ Widowed 4 □ Divorced Mexican 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ **Enrique** <u>Jurado</u> Guadalupe Ramirez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Viera 5819 Westwood Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If any Injury or once, Hilltop Service Corp. 4-22-2009 Towson Maryland 21. Si seture Livnord Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. > 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 406000 disease or condition resulting in death) /Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Melli 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes 2 ☑ No ours after death.
neral Director: After this of filled in by the funeral dire Certification: To 4⊠Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a e Funeral I Medical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune (Check only one) and manner stated. 29b. Signature and title of certifier SICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please Type or Print in Bla			
	4	For State of Maryland /	Department of Health and Mel Certificate of Death		0000 10707
		Registrar		Reg. No	3. Time of Death
Physicia /Medica	n il -	1. Decedent's Name (First, Middle, Last) ANNE H WALKER	A	Month Da	2009 0230AM
Examine	r	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	f	County of Death
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 M F 7. Age (In yrs. last to 14-14-4854)	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits 1 □Yes 2 M No
r 28a-f s	Funeral Director	MARY LAND BALT MORE LUTT 10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
eath with	eral D	311 BRIGHTWOD CLUB DRIVE 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (SpecifitYes, specify Cuban, Mexican, Puerto Ric	v Yes or No-	14. Race - American Indian,
s after d	by Fun	1 Never Married 2 Married 1 Never Married 2 Married 3 Married 3 Married 3 Married 3 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 3 Never Married 4 Never Married 3 Never Married 4 Never Married	If Yes, specify Cuban, Mexican, Puerto Ric	án, etc.)	Black, White, etc. Specify: INCHITE
72 hour			Sa. Decedent's Usual Occupation (Give kind of work done during most of working	16b. F	Kind of Business/Industry
y within giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	AN	TIQUES
be fill d oth even	To Be C	17. Father's Name (First, Middle, Last) VAMES DAVIS HARRISON	18. Mother's Name (F	First, Middle, Maidel FREEN	n Surnàme)
nd 2 shou aith and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type. Print) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9b. Mailing Address (Street and Number or Rural F BELLEMORE, RDAD, BAL	TIMORG, City	or Town, State, Zip Code) MARY (AND 21210
iges 1 and of Hez		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	of Disposition (Name of terry, crematory or other place)	109 FOR	ocation - City or Town, State
permit. Pe Departme Important any injury once.	ŀ	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensep	22. Name and Address of Facility	4 YORK RD	MONITON, MD 21111
40 E # 9	_	23a. Part 1. Enter the disease, or complications that caused the death. Deshock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition a. Complication a.	TUNS OF DEMENTIA		Onset and Death
Examiner		Due to (or as a consequence b			
executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	se of):		
pricia pe	ca	resulting in death) Last Due to (or as a consequence d.	ce of):		
tifical tig phy as the	edi				
The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23d. Date of delivery Month Day Year
w requires that the descriptions is been signed by the should be detached	by Phy	Part II. Other significant conditions contributing to death but not resultin	g in the underlying cause given in Part I.		use contribute to the cause of death?
requir been s should				1 🗆 Yes	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
	Completed			autopsy performed?	prior to completion of cause of death?
ician: Th	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (4- 14-201-0
Attending Physician: If death. ector: After this certification by the funeral director, t	on: To	1 Inpatient 2 ER	b. Time of Injury Work? 28c. Injury at Work?	e 5 ☐ Residence id. Describe how inj	6 Nother (Specify) Wy Cultury occurred
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	M 1 □ Yes 2 □ No , farm, street, factory, office 28	If. Location (Street a	and Number or Rural Route Number, te)
spital or neral Di y filled in		29a. Certifier DE-Certifying Physician: To the best of my knowle	dge, death occurred at the time, date and place, an	nd due to the cause	(s) and manner as stated.
o the Ho ithin 24 I o the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	29c, License number		Date signed (Month, Day, Year)
r ≥ ⊢ δ		1 (Alexanders	D 58303	Av	PRIL 17 2009
241		30. Name and address of person who completed cause of death (Item 23) ANUN CHNUS, M 6701 31. Date filed (Month, Day, Year) APR 2 1 2009	N Charles St Tonsu	NMI	0 2 204
Stat Registra	e ar	APR 2 1 2009 32. Registrar's Signature	park		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 2009 1:00 April 20 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 23, 192 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days Hours 1 XXM 2□ F New Jersev 88 10d. Inside City Limits

1. Decedent's Name (First, Middle, Last) Physician JAMES ALOYSIUS WALSH /Medical 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Social Security Number **Funeral** 041-18-6805 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mocked Examinar must be notified at Director Sparks Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21152 USA 14601 Western Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ⊟Yes 200 If Yes, Give Year or Dates: 1 □Yes 2XXNo Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. timore, Maryfand 2121 and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CE0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Madeline Rielly James Aloysius Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Wife 14601 Western Road Sparks Maryland 21152 Sandra Spear Walsh 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2**XX** Cremation 3 Removal from State April 22,2009 GreenMount Crematory Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease shock, or heart failure. I dons that caused the death. Do not enter the mode of cause on each line. ving, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 105 disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760

signed by the attending physician and d be detached for use as the burial-tran this certificate nours after death.

neral Director; After this y filled in by the funeral di

Be Certification: To

Physician/Medical IF FEMALE: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

27.

Medical

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

24a. Was an autopsy 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

(Specify)

1 ∐ Yes XXX No

14. Race - American Indian,

White

Approximate Interval Between Onset and Death

Year

Black, White, etc.

Manufacturing

Specify:

vvas case referred to medical	26. Place of Death (Check offly one)								
examiner?	Hospital: Inpatient 2	ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Ho	ome 5 Residence 6 Other					
Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Ascident investigation	28a. Date of Injury (Month, Day, Year)			28d. Describe how injury occurred					

3 ☐ Suicide 6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician To the best of phy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

Registrar's Signature 31. Date filed (Month, Day,

State Registrar

within 24 hours a

		State Registrar Decedent's Name (First, Middle, Las		ind / Dep <i>Ce</i>	rtificate of D	eath	2. Date of Deat	eg. No.2 U	09	3. Time of Dea
ysicia		Marvin Whitmore					Month April	17, 20	Year	2:30 P
Medic camin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or L	ocation of Dea		T	ty of Death	
		Charlestown Care	Center		Catons			Bal	Ltimor	ce
eral		5. Social Security Number 6. Sr 216-03-8489 12 Usual Residence of Decedent	ex 7. Age (<i>ln yi</i>	s. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min				place (State or Fo ntry) cyland
#		10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City L
Teg I	to	MD Baltimo	re	Catons	sville					1 Tes 2
100	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	f What Cou	intry?
4	la la	717 Maiden Choic	e Lane Apt 10		2122			USA		
	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	 Was Decedent of Hispanic Origin? (Specify Yes on If Yes, specify Cuban, Mexican, Puerto Rican, etc. 			r No- 14. Race - American India Black, White, etc.		
8	YFL	1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes 2X No			Spec	ify: V	Vhite
3 Uvidowed 4 Divorced Year or Dates: ₩₩TT					Business/Is	aducto.				
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7.8 N	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		. General		İ	Steel	Manuf	acturing
ent.	BeC	17. Father's Name (First, Middle, Last)		I ASSI.			me (First, Middle, I			Lactar III
matic ev	To B	Otho Marvin Whit	more			Janet S	heen			
other traumatic		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mail	ing Address (Street ar	nd Number or R	ural Route Number	City or Tow	n, State, Zij	p Code)
er tra		Ruth S. Whitmore	Wife	717 N	Maiden Cho	ice Lan	e Apt 105	; Cato	onsvi]	lle, MD
othe		20a. Method of Disposition	20b	. Place of Disp	osition (Name of ematory or other place)	Date	20c. Location	n - City or T	own, State
eny injury or o		1 ☐ Burial 2 🌣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	memoval irom State	Atlanti	c Cremator	v 4/2	2/2009	Glen B	urnie	, Maryla
eny inju		21. Signature of Funeral Service Local		2	2. Name and Address	of Facility St	erling As	hton S	Schwal	Witzke
€ 8		the set	1-the		Funeral Hou 1630 Edmon	me or C dson Av	atonsvill enue: Cat	e, inc	lle. M	n 21228
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de	eath. Do not en	iter the mode of dying,	, such as cardia	c or respiratory arre	est,		Approximate Interval Between
cian		Immediate Cause (Final disease or condition	5	oio						Onset and Dea
lical		resulting in death)	a. Pheume Due to (or as a cons	equence of):						ang
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Womble Fannie Lee 04 18 2009 05:12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 56 Months Days Hours Min. 1 □ M 2 😿 F 214-56-3915 Director May 1952 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evanther must be notified at Director MD Baltimore 1⊈Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3301 Leighton Ave. 21215 USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any lijuty or other traumatic event, the Medical Evander must any lijuty or other traumatic event, the Medical Evander must appear. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 4yrs. Administrator Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Carter, ၉ Hattie Beard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Jones - Son 20547 N.W. 9th Ave. Miami Gardens, FL 33169 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 04-21-09 Baltimore, MD 21. Si maure of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Palt 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athero scleretic **Physician** Conclio 49seular P9T /Medical Due to (or as a consequence of): **Examiner** 2905 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to or is a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SESC 1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 图 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 ☐ Accident a Hospins.

n 24 hours after death.

he Funeral Director: Af 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29c. License number D 15503 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) HIN STREET, BALTIMORE, 212.

Date filed (Month, Day, Year)

32. Registrar's Signature AMBTUN

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Elizabeth J. Yurcisin April 10, 2009 6:35P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cheverly Prince Georges Gladys Spellman Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June | 27 / 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) North Carolina 1□M 2X F 243-44-9834 74 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State VA Fairfax Director Alexandria 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5924 Westridge Ct. 22310 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify: Specify: Caucasian 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Hall Nina Butler Hall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Yurcisin/Partner 5924 Westridge Ct., Alexandria, VA 22310 April 16, 2009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fairfax Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia _months disease or condition resulting in death) Due to (or as a consequence of): 5 years Chronic Respiratory Failure Sequentially list conditions, if any, leading to minimize acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or se a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Kyphoscoliosis of Spine 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an

Physician /Medical Examiner

Examiner

Funeral

Director

28a-f show

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23a

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permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

72 hours after

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit ģ signed if been si should b cate has page 2 s certificate this certific al director,

Physician/Medical 2 Completed Be Certification: To

After th

Physician: The law requires that the death certificate be executed Hospital or Attending n 24 hours after death.

The Funeral Director: After the function of the funct within 2

State Registrar

ca

29a, Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Revathy Murthy

1 💆 Certifying Physician: To the best of my knowelige, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D16273MD

Cheverly,

29d. Date signed (Mopth, Day, Year)

09.

DHMH 17 Rev 1/2001

Rd.

and manner stated.

6130 Landover

32. Registrar Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and 1 - State Registrar Certificate of Death		•	1271		
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	2. Date of D		3. Time of Death		
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number) Stella Maris 5. Social Security Number 4b. City, Town, or Location of De Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If		Bal 9. Birth	4c. County of Death Baltimore 9. Birthplace (State or Foreign Texas)		
Baltimore, Maryland 21215-0036	ъ	rector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Harford Bel Air 10e. Street and Number		10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🛛 No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Modical Exacting must be notified at once.	d by Funeral Director		? (Specify Yes or Nuerto Rican, etc.)	U	I.S.A.		
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		To Be	in log Miller Young Fvel	r Rural Route Num	nber, City or Town, State, 2 Air, MD 2101			
Itimore,			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20-2009	20c. Location - City or Timonium, M	Town, State laryland		
Ba	permi Depa Impo any ii		23a. Part 1. Enter the dise se, or complications that of used the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause and ach line.	Inc.	5305 Harford Baltimore, M arrest,			
of Vital Records, P.O. Box 68760, 🧣	Physician /Medical Examiner purish the pring-transit purish the pring-t	dical Examiner	- G					
	that the death certificate to ned by the attending physic detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	livery Day Year		
	Attending Physician: The law requires crotafath. crotafth. y the funeral director, page 2 should be	Completed by P		1	as an 24b. Were at prior to death?	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of 2 No		
		Certification: To Be		28d. Describe	sidence 6 **IOther (Spe e how injury occurred (Street and Number or Recown, State)			
0	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in the filled of th	Medical C				e to the cause(s)		
	Sta Registi		te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	UM, MD 2	1093			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THELMA MARY ZOLLICKOFFER Month **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Burni Baltimore Washington Medical Center 5) en If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Hours 1 □ M 2 🙀 F 214-01-5870 93 June 6, Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1X Yes 2 □ No N/ABaltimore Director Maryland Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2730 Rittenhouse Avenue 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣 No Specify Specify: þ White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife & Mother Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Ferguson Mary Gerber ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Son) 2730 Rittenhouse Avenue, Baltimore, Maryland 21230 Mr. Harry Zollickoffer 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility No 1111y-Folymiak Funeral Rome, P.A. 21 Signature of Funeral Service Licensee Kevin E Ecker 237 East Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes 2 🖼 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide for Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

attending physician for use as the burial the detached signed by 1 d be detach this funeral After

burial-transit

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Maryland 21215-0036

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Pages

is certificate has been s director, page 2 should i after death filled in by within 24 hours a

To the Funeral D

> State Registrar

(Check only

29b. Signature and title of certifier

and manner stated

29d. Date signed (Month, Day, Year)

Dry Glam Burnia, m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

30

egistrar's Signature

31. Date filed (Month, Day, Year) APR 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 3 1 200 9 au 2130 Carolina D. Avila /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign El Salvador Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 12/05/1981 Months 1 □ M 2 ⋤ F 27 Yrs. 218-49-7220 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Experience as the notified at MD Montgomery Germantown 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number El Salvador 20874 13296 Country Ridge Drive death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify White ģ Specify: 3 Widowed 4 Divorced El Salvadoren Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental H lant: If item 27 is marked ott Alicia Avila Roberto De Paz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20874Alicia Avila/Mother 13296 Country Ridge Drive Germantown, Md. Department of Health Important: If item 27 any Injury or other trong once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/07/2009 Silver Spring, Md Gate of Heaven 5 ☐ Other (Specif 4 Donation 21. Signature of Funeral Service Lig PHINT Pd ADJERT MALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** 1 day Acute Stroke /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical After this certificate has been signed by the attending p tuneral director, page 2 should be detached for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 2XINo 1 Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation ours after death.

neral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 Ö σ. Division of Vital Records, e Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica To the within 2

State Registrar 31. Date filed (Month, Day, Year)

Shahryar Davari

29b. Signature and title of certifier

(Check only one)



26. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive Rockville, Md 20850

29c. License number D58597 29d. Date signed (Month, Day, Year)

March 31,2009

Physici /Medic Examir **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Eventine in set be natified at agnee. Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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er	4a. Facility Name (If not institution, give street and num 4213 Upper Beckleysville	4c. County of Death Carroll County							
	5. S 2:46:0-20.+6:5:58 6. Sex 1□ M 2\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	7. Age <i>(In yrs. last birthda</i> 85 Yrs.	//	er 24 Hrs. 8. [s Min. A	Date of Birth Month, Day, Year Dr. 15, 1	923 Mar	thplace (State or Foreign buntry) Y Land		
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)irect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co								
ral	4213 Upper Beckleysville Road 21074 United Sta								
Be Completed by Funeral Director	11. Marital Status 1								
ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker OWN home								
To Be C	17. Father's Name (First, Middle, Last) Chester Masimore 18. Mother's Name (First, Middle, Maiden Surname) Elma Nonemaker								
	19a. Informant's Name/Relationship (Type. Print) Barbara J. Showalter/dau	1	illing Address <i>(Street and Nur</i> Heritage Driv		oute Number, City				
	20a. Method of Disposition			Date	20c. L	ocation - City or			
	20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation 20c. Location - City or Town, State April 9, 20c. Hampstead, Maryland								
	21. Signature of Funeral Service Licensee M01072 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, linterval Be Onset and Such as cardiac or respiratory arrest, shock, or heart failure.								
	Immediate Cause (Final disease or condition								
	Due to (or as a consequence of):								
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Medical Certification: To Be Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) ■ Mon						livery Day Year		
y Ph	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given in Pa	rt I.	23e. Did tobacco	use contribute to	the cause of death?		
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Con					performed? death?		2 2 1 0		
Be	25. Was case referred to medical examiner? Hospital:		Othor	ace of Death (Ch					
5	1 Yes 2 No Prospitat. 1 Inpatient 2 ER/Outpatient 3 DOA Outlet. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?								
atio	2 Accident investigation	h, Day, Year) Injury	y Work? M 1 ☐ Yes 2	□No					
ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of buildin	and Number or R te)	ber or Rural Route Number,						
dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Me	29b. Signature and title of certifier	er	29d. Date signed (Month, Day, Year)						
	· Clus		D0060	503	4/	6/20	09		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							274		
te	Amy Staritz, M.D.: 31. Date filed (Month, Day, Year) 32. Re	ZIII ITA	nover like	Hami	sitad	MD 21	017		
ar	APR 0 7 2009	Enews S.	parker						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND31perMD,4-6-09, BW,MCGf Maryland / Department of Health and Mental Hygiene-For AMEND#12perINF,4/6/09, BW,MCO Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Clyde Bergwin edent's Name (First, Middle, Last) D3 2009 30 45 AM **Physician** /Medical County of Death 4b. City, Town, or Location of Death Examiner Rehabilitation Center Beltiesda 1 ontrumen 2019 9. Birthplece (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number Days **Funeral** 79-10-396 Months M 2 F 0 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Copnty 10a State s 23a or 28a-f ehow 1 Yes 2 No lont 650 mon **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5721 ansvenon death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 11. Marital Status Pages 1 and 2 should be filed within 72 hours after dement of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Item ury or other treumatic event. Ina Medical Examiliat? 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) air 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bercini Nyberc ပ 1+XQ 19a. Informant's Name/Relationship Type, Print) Duch ter 19b. Mailing Address (Street and Number or Rural Route Number, dity or Town, State, Zip Code) 10213 win-Anderson OL MIL 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 k. Locati . - City or Town, State 4-1-2009 20a. Method of Disposition Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Be Itsuille he sapporte Cire materi 21. Signature of Funeral Service Licenses permit. < Bergwin-Anderson 22. Name and Address of Facility 02 1020 dir4 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Moca cereal /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) I□Yes 2□No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 22 No 2 No 1 ☐ Yes 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA After this 28b. Time of Injury funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 853558 mo Merch 31, 2007 30. Nim and address of person who completed cause of death (Item 23a) (Type, Print) (ELL) CROPE Aul OADha He O(nesimo 5063 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 08 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** STACEY L. BROTHERTON APRIL 2009 3:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Birthplace (State or Foreign Country) If Under 1 Year | If Und Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Days 1 □ M 2 □XF Months Hours 39 Director AUG. 13,1969 WASH. 219-72-5104 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location is 23a or 28a-f show 1 √ Yes 2 No Funeral Director MD. CALVERT NORTH BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 9520 SEAGULL CT. 20714 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify Completed by 3 ☐ Widowed 4 🔀 Divorced WHITE "natural" other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DENTAL ASSISTANT DENTAL OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental 27 is marked of traumatic even TERRY L. WEAVER PHYLLIS MURPHY ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 WEAVER/MOTHER P.O. BOX 518, WARDENSVILLE, WEST VIRGINIA 26851 PHYLLIS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 4-3-2009 RIVERDALE, MD. 21. Signature of Funeral Service Lice 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** BREAST CANCER WITH METASTASIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner OCULAR MELANOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the buriai-transil CHOLECYSTITIS Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been si e 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate ha perform 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. reral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a, Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer D65953 APR. 1, 2009 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co HDAKU ONUK**O**GU, 1500 FOREST GLEN RD., SILVER SPRING, MD. 20910 DR. M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State 2009 APR 06 Registrar

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Anna R. Boothe **Physician** 3:00a M April 2, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F MD 93 August 7, 1915 Director 579-52-6393 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examinar must be nutfilled at 1 ☐ Yes 2 X No Director Potomac MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20854 10432 Democracy Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 210 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2XXNo Baltimore, Maryland 21215-0036 White 1 □Yes 2XX No Specify: Specify: Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Anna Guy Joseph Arthur Raley ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10432 Democracy Lane, Potomac, MD 20854 David L. Boothe / Son permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 6, 2009 Silver Spring, MD Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. West, Silver Spring, MD 20901 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Physiclan; The law requires that the death certificate be executed and -trag Due to (or as a consequence of): burial physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 🔁 No Ö been signed by the should be detached 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions/pontributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform 2 KNo certificate 2 🎜 No 1 ∐Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1011 6 31. Date filed (Month, Day, Year) State NA

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 4, **Physician** 2009 **Black** 7:45 A. Richard Eugene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Golden Living Center Frederick Frederick 8. Date of Birth (Month Day, Oct 17, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 M 2 □ F 77 Pennsylvania **Director** 187-24-2321 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show If is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Externity or must be profiled at Maryland Frederick Frederick 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Rocky Mills Drive 21703 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 3 General Manager automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin R. Black Rhoda Raifsnider ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lena R. Black - wife 4701 Rocky Mills Drive, Frederick, Maryland 21703 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stauffer Crematory Frederick, Maryland 4-6-2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Si sture of Funeral Serves Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ngative Physician disease or condition resulting in death) /Medical Due to (a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached for P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 s autopsy performed 2 🗆 No 1 ☐ Yes 2 🖵 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 62223

DHMH 17 Rev 1/2001

State

Registrar

441

ORIGINAL

DRIVE PREDERICK MD-21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYETN BOLARUM

APR 07

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month April 04 2009 10:55 a^{M} George Thomas Biden, Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 700 S. Center Street Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 19 Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** ^{Yea}r) 1923 Months Days Hours 1 → M 2 □ F 85 MD Director 220-18-4297 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 700 S. Center Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify ò Specify 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Koppers Company s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 is marked other th traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Narer George Thomas Biden, Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 700 S. Center Street Westminster, MD George T. Biden, III/son permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 □ Cremation 3 □ Removal from State Westminster Cemetery 4/07/2009 4 □ Donation 5 □ Other (Specify) Westminster, MD 21. Signature of uners Printed Perseral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Ischemic cardiomyopathy three yrs /Medical Due to (or as a consequence of): Examiner Coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Emphysema 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Tes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

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Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Howard G. Lanham,

APR 06 2009

31. Date filed (Month, Day, Year)

D17040

215 Washington Heights Medical Center

Westminster, MD 21157

April 6, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Clarence Edwin Bassler April 0250 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3400 Hyser Road Taneytown Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 29 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours ^{Year)} 1933 **1** M 2 □ F 76 MD 219-36-2326 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Carroll MD Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 USA 3400 Hyser Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 DXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Farm Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E. Edwin Bassler Irma May Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Hyser Road Taneytown, MD 21787 Joan Bassler/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 04/08/2009 20c. Location - City or Town, State 1 XBuria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signature Juneral Service Licensee Printed Aunerality Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATITIS disease or condition resulting in death) 20 20,45 GALL STOPE OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 **N**0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner sician and burial-transit Box 68760 attending physician for use as the buria The law requires that the death certificate be signed by the a d be detached f P.O. Division of Vital Records, certificate To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica After this c Certification: To neral Director: A

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examinar must be multified at

"natural", or

other

of Health and Mental F fitem 27 Is marked otl r other traumatic ever Pages 1 and 2 should be

Department of Health ar Important: If item 27 Is any injury or other trau

Physician

/Medical

event, the Medical

Director

Funeral

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Completed

Be

Examine

Physician/Medical

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Completed

Be

Medical

29a. Certifier

the Maryland

death

filed within 72 hours after

Maryland 21215-0036

altimore,

permit.

/Medical

AW ١O

State Registrar 29b. Signature and title of certifier

29c. License number 0014317

Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. LIPTHICUM, MI WILLIAM

ONE KIPGS DRIVE, TAPEYTOWN MD 21787

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Day Year 5:07 Pm Elsie Evelyn Beall 2009 Apri1 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Clinton Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days **Director** 89 218-54-7956 08/29/1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits event, it is Medical Examiner must be notified at Director 1 ☐ Yes 2**X** No 28a-f Maryland Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 15408 Nottingham Rd 20772 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or þ 1 ☐ Yes 2\time{No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any hijury or other traumatic event, it a Med once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ James O. Cross Edna I. Padgett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John F.</u> Beall (Husband) 15408 Nottingham Rd. Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 04/08/2009 | Clinton, MD 21. Signature of Funeral Service Licensee MO1555 22. Name and Address of Facility Lee Funeral Home.Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Onset and Death cevelino Vascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Hyper tension Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autonsy performe certificate rmed? 2 🖾 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 □Yes 2 □ No within 24 hours after death To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) 0042049 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Marlboro Champalo-> MA 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			State of Maryland / Dep 1 - State Amend #14, 4-8-09, per FHDR, HGU	artment of Health and I Prificate of Death	Mental Hygie	ne No2009 2723
	П		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Gregory Sheldon Blanks, Jr.		April 4	Day 2009 10:45 A M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Casey House	Rockville		Montgomery
П	Funeral		Social Securify Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		420-11-0378	Worters Days Flours Will.	Jan 16, 1	976 California
	pu »		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo	partian		10d. Inside City Limits
	aryla shov	5				1 ☐ Yes 2 XNo
	he M	ecto	MD Montgomery Burtonsvi			
	with t	ä	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	sath v	eral	3838 Berleigh Hill Court	20866	US.	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, Ite Medical Example or must be motified at	by Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify. African American
215-0036	2 hou		15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b	b. Kind of Business/Industry
2	in 72	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	king	- ·
7	d with giene er tha	E O	10 Labo	rer	C	onstruction
ם		Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Surname)
yland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, ILE M	To E	Gregory Sheldon Blanks, Sr.	Bessie I	ouise Ale	xander
Mar	2 sho and is me			ng Address (Street and Number or Ru		
~` ≥	and ealth m 27			Berleigh Hill Ct.		
0	jes 1 t of H If iter			matory or other place)		: Location - City or Town, State
Ē	Pag tmen tant: lury	1.8	4 □ Donation 5 □ Other (Specify) W. Arunde	el Crematory; 04/0	07/09 ode	enton, MD
baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.				P.O. Box 784 larksville, MD 21029	
I		Approximate				
	Physician	8	shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Osteosarcoma Due to (or as a consequence of):			
	Examiner					
	73 #	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
	ocuter nd ransi	Examiner	that initiated events c.			1
Š	e exe yan a urial-l	Ä	resulting in death) Last Due to (or as a consequence of):			
8/60,	ate b	dical	d			
Ď	e as		IF FEMALE:	•		
o n	ath o	ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery Month Day Year
	the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		monal Bay 10 a
7,	hat the		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did tobacc	co use contribute to the cause of death?
ecoras,	sign d be	d b	3	macri, mg caaco groot ar rain		2 No 3 Probably 4 H Unknown
Ö	requ been shoul	etec				
ě	has ge 2 s	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
13	n: Th ficate r, pag				1 □ Yes 2 🗓	
5	sicial certi recto	Be	25. Was case referred to medical examiner? Hospital:	Othor	th (Check only one)	
5	Physral di	5	1 ☐ Yes 2 ☒ No	III 3 DOA 4 D Nursing Ho	ome 5 Residence 28d. Describe how in	e 6 Xother (Specify) hospice
	ding h. Afte fune	ţi	1 ☑Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	Zou. Describe flow ii	njury occurred
VISION	Atten deat ctor:	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		28f, Location (Street	t and Number or Rural Route Number,
2	al or after after I Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	tate)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place	, and due to the caus	se(s) and manner as stated.
	n 24 n 24 n 24 n Pietel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	rred at the time, date	and place, and due to the cause(s)
	Vithi To th	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Jecelyne Kotlethcher, mj	Jeo 63 747	Apı	ril 6, 2009
1	200	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
1	1/00		Jocelyne Kouatcheu, M.D. 6001 Muncast	ter Mill Rd. Rockv	ille, MD 2	20855
	Stat	te	31. Date filed (Month, Day, Year) 8 2009 32. Registrar's Signature	hadl		
	Registra	al?	press p. f.	acked		

09-02699 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Raymond Boyle State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day April 5, 2009 1241 hrs Raymond Medical Examiner Frederick Boyle 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Coun West Africa Min Months Days Hours 580-27-5187 Director $_{1}\mathbf{X}_{\mathsf{M}}$ 54 May 5,1954 Sierra Leone, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Silver Spring 28a-f show Montgomery Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 20901 10751 Venetia Mill Circle; Apt. 1A Sierra Leone, West Africa Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces? Married 2 X No Yes **Black** Yes, Give Yea 2 X No specify Specify: Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 Unemployed 12th grade None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, æ Maggie Wood Joseph Boy1e (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Maryland 20901

etia Mill Circle, Apt. 1A; Silver Spring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Fitem 27 is m r tranmatic MD 10751 Venetia Mill Circle, Apt Ollivette Boyle Sillah (Sister) 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) t: Hi 1 X Burial 2 April 18,2009 Cremation 3 Removal from State Silver Spring, Maryland tant: Gate of Heaven Cemetery Donation 5 Other Specify 22. Name and Address of Facility R. N. Horton Company Morticians, an re of Funeral Se vice kicensee Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical AMENDED 23a, PII, 27, perME, g890 4/23/09 TT attending physician or use as the burial X UNPENDED Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ģ Yes 2 No 3 Probably 4 V Unknown ۵ Chronic alcohol abuse The law requires Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Nο ✓ Yes 2 1 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification XX Natural Yes 2 Pending To the Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 24 hours after Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) April 7, 2009 O.C.M.E. leted cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Regis rar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MARCH 30 Day 4:15 P 2009 BURSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY SILVER SPRING APEX NURSING HOME 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Months Hours Min. 1 M 2 KF 74 Director 066-26-3156 VIRGINIA 02 - 24 - 1935Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits WASHINGTON r 28a-f sh notified DC Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r LUZON AVENUE N.W. #214 20012 U.S.A. 6600 Funeral ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2\2\0 If Yes, Give Year or Dates: Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 🌠 o Specify: þ Specify: BLACK 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical NATIONAL WELFARE Elementary/Secondary (0-12) College (1-4or 5+) COMMUNITY ORGANIZER 10th other of Health and Mental Hygi item 27 is marked other other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SADIE COLEMAN WILLIE BURSON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 SUFFOLK AVENUE #320 CAPITOL HEIGHTS, MARYLAND AVERY BURSON/ DAUGHTER Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XXX emation 3 ☐ Removal from RIVERDALE, MARYLAND RIVERDALE PARK 04-06-2009 4 ☐ Donation 5 ☐ Other (Specify) ature of uneral Service Hoens 22. Name and Address of Facility OHN T RHINES FUNERAL HOME LLC 3005 12th STREET N.E. WASHINGTON, DC 20017 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage -nd unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, larry, and the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy abetus 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No a Hospital or Attendi 24 hours after death. s Funeral Director: A 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD; 15216 DINO DRIVE; BURTONSVILLE, MD20866 State

DHMH 17 Rev 1/2001

Registrar

avi	a Bennett		- For State legistrar	of Maryland / D	-	ent of Healt ate of Death			eg. No.	200	9 1272
vled	Physicia lical Exami	ın/	1. Decedent's Name (First, Middle,Last	ENNETT				2. Date of Dea Month April 9, 20	Day	Year	3. Time of Death 0326 hrs
. المنطق			4a. Facility Name (if not institution, give	street and number)			own, or Location of Dea		4c. (County of Death	
	Funeral		Southern Maryland Hospita 5. Social Security Number 6. Security Numbe		yrs. last birth	Clinto	r 1 Year If Under 24H	rs. 8. Date of Bi		ince George	hplace (State or Foreign
	Director			M 2 F 53		Yrs. Months		in. 10-30		Cou	untry)
	/ any	ı	10a. State 10b. County	100	:. City, Town	or Location					10d. Inside City Limits
7	Maryland 28a-f show d at once	ğ	MD PRINCE O	GEORGE'S	TEMPLE	HILLS				()4() + 0	1 X Yes 2 No
7	e Mary or 28a- ïed at	irec	10e. Street and Number			10f. Zip				en of What Cour	.try?
.	5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Funeral Director	4523 OLD BRANCH A	12. Was Decedent Eve	er in U.S.	13. Was Decede	748 nt of Hispanic Origin? (USA 0- 1		can Indian, Black,
	or iten	Fune	1 Never Married 2 X Married	Armed Forces? 1 Yes 2 X	No		y Cuban, Mexican, Puer	to Rican, etc.)		White, etc.	
	ırs afte ural", ıminer		3 Widowed 4 Divorced 15. Decedent's Education (Specify on	or Dates:	ted) 16a, [X No specify: Occupation (Give kind of	of work done		Specify: WH] and of Business/l	
	72 hou n "nat	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of wor	king life. DO NOT use r	etired)			
	5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed by	9TH		P	LUMBER	I 40 Martinada Nic	me (First, Middle,		NC MECHA	ANICAL
		Be C	17. Father's Name (First, Middle, Last) ROBERT EDWARD BEI	NNETT, SR.				BETH MAE			
	ID 2121 should be f and Mental 77 is marked matic event,	2	19a. Informant's Name/Relationship (T	pe, Print)			(Street and Number of				
	e, MD 1 and 2 sho Health and item 27 is		DEBORAH A. BENNE'. 20a. Method of Disposition	rr / Wife		523 OLD of Disposition (Nan	BRANCH AVE	NUE TEM Date		HILLS, N	
	- x - = e		1 Burial 2 X Cremation 3		cremate	ory or other place)				•	
	Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licens		METROP	22. Name and	REMATORY 04 Address of Facility M	<u>+-16-200</u> ARSHALL'	S FU	LEXANDRI NERAL HO	A, VA DME OF MD
		4	Serl & Noun	DEREK E. S	LOCUM		8 SUITLAND			LAND, MI	The second secon
	Physician /Medical		23a. Part I. Enter the disease, or compl failure. List only one cause on ea	ications that caused the ch line. Cocaine int							Approximate Interval Between Onset and Death
	xaminer		Immediate Cause (Final disease a. or condition resulting in death)	Oue to (or as a conseque	ence of): Ca	ardiovas	cular disea	se			
		اير	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):				_		
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated								
	od d ansit	Exa	evento resulting in death, East	Due to (or as a conseque							
	ox 68760, eath certificate be executed attending physician and or use as the burial - transit	dica	X UNPENDED	AMENDED 23a,	27,288	a-f,perMI	E, g890-4/2	2/09 TT			
	760, ficate b g physic sthe but	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		Fetal death	3 Ectopic pres	nancy		Date of deliver. Month	y Day Year
	Box 687 death certifice the attending p	iciar	past 12 months?	4 Pregnant at time	e of death					WOTH I	Jay Tou.
	ed f	Physician/	1 Yes 2 No 9 Unknown Part II. Other significant conditions	9 Unknown contributing to death bu	it not resulting	a in the underlying	cause given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
	, P.C res that signed be deta	Ď					,	1 Y	es 2	No 3 Prol	bably 4 🗸 Unknown
	ords, w requir is been s should I	lete						24a. Was	s an opsy		utopsy findings available completion of cause of
	Reco The law cate has	Completed							ormed?	death?	es 2 No
	Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	ospital:	4 500		26.Place of Death (Che		75		
	Division of Vital Records, P.O. Into Attending Physician: The law requires that the reafter death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	-: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	2 ER/O		28c. Injury at Work?	28d. Describe	Resider how inju		я.
	ion treudin leath tor: A the fur	Certification:	1 Natural 5 Pending 2 Accident Investigation	T1 / /0 /00	- 1	2:51 pm	1 Yes 2X No	unk			
	Divis al or Ar after of Directed in by	rtific	3 Suicide 6 X Could not determined	28e. Place of Injury	- At home, fa	arm, street, factory	, office building, etc.	28f. Location or Town,	(Street ar State), 4	Number or Ru 523 Ω1d	ural Route Number, City Branch Ave
	Lospits 4 hours 7 uners ely fille		4 Homicide	an: To the best of my kr		ath occurred at the	time, date and place, a				
	Division To the Hospital or Attendition thin 24 hours after death To the Funeral Director: A completely filled in by the ft.	Medical	one) 2 Medical Examiner								
	2	×	29b. Signature and title of certifier			290	c. License number			Date signed (Mo	nth, Day, Year)
			30. Name and address of person who o	completed cause of deat	h (Item 23a)		O.C.M.E.		April	9, 2009	
	By		Ana Rubio MD. Assistar	nt Medical Examin	,	Penn Street, E	Baltimore, MD 212	201			
	S Regis	tate trar	APR 1 8 2009	32. Registrar's S	Signature	1				-	
				/r· /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 1213 BROWN Rick no /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** South DE AND Salishuen Wicomico 100 AVE If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**⊠**M 2□F Months Days Hours 214-30-9058 30-1934 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 □Yes 2 No Wicomico Director MARULAND PALISDU 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or USA 21801 AVE South DELANO 1007 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces: 1 Nos 2 Nos If Yes, Give Year or Dates: 1955 - 59 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE Nurse GERIATRIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EthEl MAE BROWN Lucious .1) EVOE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BROWN Eliza M) C! 20646 ARTHA PURNER ION -ATA 20c, Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Seburial 2 ☐ Cremation 3 ☐ Removal from State Important: If 4 09 4 ☐ Donation 5 ☐ Other (Specify) RINCESS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility an, Kell SEWAR FUNERAL HERNE 10 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ling physician and e as the burial-trans Due to (or as a consequence of): the attending physician Physician/Medical IE EEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to Teath but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 1□ Yes 2**X**/No or Attending Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 R/Outpatient 3 DOA 1**☑**Yes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 ☐ Accident 5 ☐Pending 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760,

within 24 hours a To the Funeral I To the Hospital completely

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 07

29a. Certifier

(Check only one)

29b. Signature and title

Carroll E 32. Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

29c. License number

29d. Date signed (Month, Day, Year)

21801

VVD

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 09 HddiE EVA 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MON GO MERY
9. Birthplace (Sear) Country) GREALER HOME 8. Date of Birth (Month, Day, Year) tate or Foreign Social Security Number **Funeral** Months Days 1 ■ M 2 🗷 F 218-78-4490 Usual Residence of Decedent NORD **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland 1 X es 2 No Completed by Funeral Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 14. Race - American Indian, 20852 SOAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2/2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DomESTIC NONE 06 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ ENS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FIORICA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State HCRES 4 Donation 5 Dother (Specify) GREEN 21. Signature of Funeral Service 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanca /Medical Due to (or as a consequence of): Examiner Re Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ar as a consequence of) Examiner and I-transit Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No. 9□Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours fer deaf To the Funeral Director. 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Juzh. mina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) efferson St Rocicville 1801 Fazli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 07

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:45 a_M Helen Crystal April 02 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 10813 Bucknell Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗷 F New York Director 82 May 10, 1926 116-14-9906 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f sl Examirer must be notified 1 ☐ Yes 2 X No Director **Maryland** Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 10813 Bucknell Drive 20902 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian. Black, White, etc 1 and 2 should be filed within 72 hours after the that the and Mental Hyglene.

127 is marked other than "natural", or itel ther traumatic event, it a Madical Exemiter. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify. <u>ک</u> Specify 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Ralph A. Umans Celia Weiss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.
once. Maxwell Crystal - Husband 10813 Bucknell Drive, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Judean Memorial Gardens 04/05/2009 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List c ly one sause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Liver Failure 1 month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Adenocarcinoma 2 months Sequentially list conditions, if any, leading to immediate cause the deliver charge Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₹ 1 ☐ Yes 2 🔼 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 □Yes 2 No Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral l 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hound to the Fune completely file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٩ D35996 April 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Burrell, M.D., 2730 University Blvd, West., Suite 400, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year March 31, 3:04P. Chick М Wəlter 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's 5503 Belva Street Lanham 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F Washington, DC 578-20-7804 87 Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10b. County Maryland Prince George's Lanham 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5503 Belva Street 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Xives 2 □ No if Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Signal Repairman D.C. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sydney Weelock Joseph Ernest Chick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis M. Chick -son 18Y Ridge Road Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cometery, crematory or other place) Cedar Hill Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/4/2009 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20**7**05 Worald 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concestive Heart Failure vears disease or condition resulting in death) Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-transi and physician at the burial attending pl funeral director,

cate has been signed by the page 2 should be detached certificate After this

Examiner Physician/Medical ۾ Completed Be Certification: To

death. nours after death.

neral Director: A

filled in by the fu 24 hours a

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 hor To the Fune completely fi 0+1

27. Manner of Death 1 Natural

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

25. Was case referred to medical examiner?

1 Yes 2 No

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

and manner stated

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c, License number

24a. Was an autopsy performed?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

April 1, 2009

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

Peter M. Schissler, M.D. 7500 Greenway Center Drive, #430 Greenbelt, Maryland 20770

28c. Injury at Work?

D22780

1 ☐ Yes 2 ☐ No

State Registrar

Medical

31. Date filed (Month, Day, Year) 06



State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	Ce:	rtificate of l			Reg. No.	9 12731
	Physicia	an	1. Decedent's Name (First, Middle MARY ELOISE CHA					2. Date of De	Zay 200	3. Time of Death 9 18:05 M
ر	/Medic Examin	aı er	4a. Facility Name (If not institution	n, give street and number)	nnn	4b. City, Town, or	Location of Death		4c. County of D	
	Funeral		FORT WASHINGTON 5. Social Security Number	6. Sex 7. Age	LEK e (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir	th 0	Pirthplace /State or Foreign
	Director		577-50-9376 Usual Residence of Decedent	1 M 2 F	73 Yrs.	IVIOITII Days	Tiodis Willi	DECEMBER	(12, 1935 WA	SHINGION, D.C.
	aryland show d at	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 Y Yes 2 □ No
	r 28a-f	Directo	MARYLAND PRINCE 10e. Street and Number	GEORGES	FORT WASI	10f. Zip Code			10g. Citizen of What	Country?
	ath with s 23a o nust be		1318 PALMER ROA		Tuna in 11 C	2074		ocify Voc or N	UNITED ST	ATES
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	I If Yes, Give	le le	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	Rican, etc.)	Black, W	white, etc. BLACK
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212	ed withii giene. er than t, the M	Comp	Elementary/Secondary (0-12)	2 YEARS	*) N	URSE				RE INDUSTRY
and	be od o	To Be	17. Father's Name (First, Middle WILLIAM LEO WAT						e, Maiden Surname) LEY WATERS	1
Maryland 21215-0036	2 should be and Menta is marked raumatic ev	-	19a. Informant's Name/Relations	ship (Type. Print)	I	-			ber, City or Town, State	
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		JOSEPH E. CHASE			osition (Name of ematory or other place		Date	20c. Location - City	
Baltimore,	0 O		1 W Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specify)	RESURREC	TION CEME	TERY APR	-		N, MARYLAND
Ball	permit. Pag Department Important: I any Injury o once.		21. Size allure of Funesal Service	ORNTON JOHNSO	N MOO583 3	HORNTON F 3439 LIVIN	IGSTON ROA	AD. IND	IAN HEAD.	MARYLAND 20640
PI E	Compared the principle of the purial-transit as the burial-transit as the burial-transit as the purial-transit	edical Examiner	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence of):	nter the mode of dyir	ng, such as cardiac	or respiratory	iCER	Approximate Interval Between Onset and Death
Box	ath cert attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	у		23d. Date of Month	,
rds, P	equires that en signed b ruld be deta		Part II. Other significant condit	tions contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.		/	te to the cause of death? □ Probably 4 □Unknown
Division or Vital Records, P.O.		Completed by							opsy prior deal	re autopsy findings available r to completion of cause of th? Yes 2 □ No
. Vita	Attending Physician r death. ector: After this certific by the funeral director.	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2 ER/Outpatio	ent 3 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H		oñe) sidence 6 □Other (Specify)
io u	ing Phy After thi		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of Inju		Wo	ry at rk?]Yes 2 ∐ No	28d. Describe	how injury occurred	
Divisio	To the Hospital or Attending Physician. within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could	minod 200. Flace Ul III]	ury - At home, farm, s c. <i>(Sp</i> ec <i>ify)</i>		ites Elino		(Street and Number cown, State)	or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certify (Check only one) 1 Certify	ring Physician: To the best al Examiner: On the basis of and manner st	of examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) and manne e, date and place, and	er as stated. If due to the cause(s)
	To the within To the	Me	29b. Signature and title of certif	ier	1	29c. Licens	se number	/	29d. Date signed (A	Nonth, Day, Year)
			30. Name and address of person	on who completed cause of o	death (Item 23a) (Type	e, Print)	0-101	0	4-6-	ANDY
	063		Louis Kauf	man mo -	/2070 0	Id Line	Centre,	Sente 3	07, Weldn	t, ms 20602
3	St Regist	ate rar	APR O	7 2009 Sine	un B. 4	parked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month **Physician** 2:39 PM 2009 April 4. Melvina Comer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Cheverly Prince Georges Hospital If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 09/16/1943 5. Social Security Number Hours 65 366-44-9763 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No Director Maryland St. Marys Mechanicsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20659 U.S Funeral 37431 Asher Rd . A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify ģ Specify: White 3XXVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Administrative Associate</u> <u>Government</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beulah Shoemaker ပ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37431 Asher Rd. Mechanicsville, MD 20659 Kimberly Hall 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lee Crematory 04/08/2009 | Clinton, MD 21. Sign are of Funeral Service LicenseeMO1555 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that care de the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) WIRK Due to (o Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junkhown 24b. Were autopsy findings available 24a. Was an autopsy performe 2 DA 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 100 1 | Yes 1 I I Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, the use as for been signed by the should be detached certificate has b Attending Physician:

Funeral

Director

if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examination must be modified at

death v

1 and 2 should be filed within 72 hours after

Pages 1 permit. Pages Department of Important: If It any injury or o once. Ę.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

After this c funeral dire death.

Physician/Medical \$ Completed Be ication: To

1 A Natural

2 Accident

3 Suicide

2	s after al Direct	Certif	4 🗌 Homicide
	re Hospit 24 hour re Funera	dical (29a. Certifier (Check only one)
	Vithir Vithir Comp	Me	29b. Signature ar
_			

State Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated b. Signature

5 Pending investigation

6 ☐ Could not be

determined

1 ☐Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4/6/2009 **Physician** CREED CHARLES CLEVELAND SR. /Medical 4c. County of Death 4a. Facility Name (II not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Hyattsville St. Thomas Moore Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Months | Dave | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 🛛 M 2 🗆 F Months Days 8/28/1932 Director 76 Washington, DC 260-44-0115 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it of Notical Examinations to rotified at 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County Director 1X Yes 2 No Maryland Prince Geogre's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7831 Michele Drive 20785 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 2 X No □Yes 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Snecify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Protective Serviceman D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Johnnie L. Cleveland Jennie Mae Bassham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; if item 27 is any Injury or other trau once. 7831 Michele Drive Landover, Maryland 20785 Laura E. Cleveland / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 4/11/2009 21. Signature/of Funeral Service Licensee 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Parth. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Qnset and Death Immediate Cause (Final Arterioschendic Genebrovasalar Discess **Physician** disease or condition resulting in death) eails /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by t d be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen uncers he lopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate Vaswian Dementsa 2 No 1 ☐ Yes 2 ☐ No Vital 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 No death. 2 Accident To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 101852 APRIL 6 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbary Rel HyattsuilleMD20181 State Registrar

eil l	Dellacamera		State of Maryland / Department of He -For State Certificate of De	ealth and Mental Hy eath	ygiene Reg. N	lo. 20(09 1273			
	Physicia	n/ 1	legistrar 1. Decedent's Name (First, Middle,Last) Neil Della Camera Neil Graham Della—Ca	mera	2. Date of Death Month Da April 9, 2009	y Year	3. Time of Death 1337 hrs			
/lec ~	lical Examir		4a. Facility Name (if not institution, give street and number) 4b. Ci	ity, Town, or Location of Death		4c. County of Death				
			Affile Ardider Medical Genter	nnapolis Under 1 Year If Under 24Hrs	. 8. Date of Birth(M					
	Funeral Director		5. Social Security Humber 6. Dox	onths Days Hours Min.	8-29-19	45 Forei	rthplace (State or gn Washington, buntry)			
			Usual Residence of Decedent				10d. Inside City Limits			
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X	with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 10f	f. Zip Code	10g.	Citizen of What Cou	untry?			
0	the Manager 1		of filadeli opizing ridge	20610		ited Stat	rican Indian, Black,			
1	tems 2.	Funeral	1 Never Married 2 V Married Armed Forces?	cedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	l			
	fter des		3 Widowed 4 Divorced If Yes, Give Year 1 Yes	No specify:		Specify: Whi				
	hours a natura	ed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	work done [16 tired)	Sb. Kind of Business Naval Dis	strict				
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 11 Fire1	fighter 		of Washi	Ington			
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	re, N s 1 and f Healt ff item er trav	ı	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other remainded to the company of the	place)						
	Baltimore, permit. Pages I ar Department of Her Important: If ite Injury or other tr		4 Donation 5 Other Specify: Fort Lincols	n Cemetery 4/	16/2009 rt Lincol					
	Balt permit Depart Impor	- 1	Maria Mariana Chartley 3401	Bladensburg R	d. Brent	wood, MD	20722			
-	Physician		23a. Parti. Enter the disease or complications that caused the death. Do not enter the n				Approximate Interval Between Onset and Death			
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		Ш	Sequentially list conditions, b.							
		iner	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):							
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	of Vital Records, P.O. Box 68760, g. Physician: The law requires that the death certificate be executed fler this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transit	ical	X UNPENDED X AMENDED #1, 23a,PII,27,	perME, G890 4/	/22/09 TT					
	760, icate be physical the burn	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	death 3 Ectopic preg	inanci/	23d. Date of deliv	very Day Year			
	Ox 68760, eath certificate be attending physic for use as the but	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	death 3 Ectopic preg	griancy					
	Box e death o the atter	Physi	1 Yes 2 No 9 Unknown C Unknown	derlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?			
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	ds, I equires seen sig	eted			24a. Was a autops	y pr ior	autopsy findings available to completion of cause of			
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	of Vital Records, P.O. ling Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	Be C	25. Was case referred to medical	26.Place of Death (Che		Residence 6 O	ther:			
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	~ ∄ ⊸ a	ië E	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No						
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B	To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed				
1		2	Colorleur	O.C.M.E.		April 10, 2009)			
7	_		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn 3	Street, Baltimore, MD 2	21201					
		State	e 31. Date filed (Month, Day, Year) 32. Registrar's Signature							
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			Registrar	41	Cer	uncate or i	Jeani	2. Date of Deat			3. Time of	Death
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	Funeral			Sex 1. Age (In yrs 1. 22	Yrs.	Months Days	Hours Min.	July 31	Year)		_{try)} ` sylvan	
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and	A ==	F	10a. State 10b. County	10c. C	City, Town or Lo	cation				11	0d. Inside C	ity Limits
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the the	288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	What Coun	try?	
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death	78 2 III	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No-		ace - Americ		
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1215-0036 within 72 hours after death with the Maryland		Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10 105 200 100	Specif.					
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Maryland 21215-0036 od 2 should be filed within 72 hours af	Department of Health and Mental Hygiene. Importants or Items 23a or 28a-1 show Importants If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show eny injury or other treumatic event, the Medical Examinat must be notified at 200ce.	2	Michael Cumming						O'1 T	- Canto Zio	Cartal	
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and and	ealth m 27 mer tr		Michael Cummings			osition (Name of	ntree Lai	Date Ditte	20c. Location			
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Baltimore, permit. Pages 1 ar	apart port ny inj		21. Signatu H of Eurer H Service	ensee			ess of Facility					
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de ly one cause on each line.	eath. Do not enf	ter the mode of dyli	ng, such as cardiad	or respiratory ar	rest,		Interval Be	etween
, Pt	nysician		Immediate Cause (Final disease or condition	Thauma	itc t	znain 1	njony	100	`		14e	ar
	Medical		resulting in death)	Due to (or as a cons	equence of):	- / .	a had	-0.0-	1000		,	
	xaminer		Sequentially list conditions,	b	15+en	1 8 11 6	-673 -101 (1	1/300	100	1-1		
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ecute	and frant	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	editence of).		W/Y	012				
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Box leath cert	ottenc for us	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ Fi 4 □ Pregnant at time of	etal death 3	☐Ectopic pregnand ☐ Other (specify) _	ry			Month	Day	Year
က က	the c	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	a dodin 5 L	_ Other (apociny) _			:			
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Vision	death tor: the	cal	3 ☐ Suicide 6 ☐ Could no	t be 290 Place of Injury . A			(28f. Location (Street and Nu			mber, Sun
Division of	after death	Certification:	4 ☐ Homicide determin	building, etc. (Special Street)		cliba		City or To	21	@ m	sex Rd	MO
- e	ours ours filled	C	29a. Certifier 1 ☐ Certifying	Physician: To the hest of my	knowledge dea	th occurred at the	ime, date and plac	e, and due to the	cause(s) and	manner as	state MIA	Minitur
ğ	24 h Fur etely	ledical	(Check only 2 Medical Ex	kaminer: On the basis of exam and manner stated.	ination and/or it	nvestigation, in my	opinion, death occ	urred at the time,	date and pla	ce, and due	to the cause	(slowing.
	within 24 hours after de To the Funeral Directo completely filled in by th	B	29b. Signature and title of certifier	1	,		ise number		29d. Date sig			
•	> - 0		1 Drand	ele-lostin	1 lan	1	0185.	2_	4, 3	-09		
	5		30 Name and address of person w	ho completed cause of death (Item 23a) (Type	, Print)	ol85.	0111		-11 1	11 -	010
			PAUL A. D	-1 In D= ALI	117 17	QUED	usbury.	Kel Hy	EUSV.	110 M	12 40	181
	St	ate	31. Date filed (Month, Day Year) APR 0 8 2009	32. Registrar's Si	gnatus	1	C					
	Regist	trar	APR U O ZUUS	bearing b.	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 7 1. Decedent's Name (First, Middle, Last) Year 2009 Month Physician 4:30 a April Marion J. Dobson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Rising Sun Calvert Manor Healthcare Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗹 F NJ 148-14-3812 84 January 11, 1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director PA Chester Oxford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 19363 1214 Lewisville Rd. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Household 12 Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Sylvia Henek Charles Klaus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1214 Lewisville Rd., Oxford, PA 19363 Craig Dobson/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA R.A. Ferris & Co., Inc. April 8, 2009 21. Signature of Cup (14) Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Infection URINARY **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) Р þ Completed 2 Be P 2 Certification:

Examiner sician and burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician for

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 Department of H Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica

1 □ Yes 2 D No 9 □ Unknown	9□Unknown	
		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Cerebral V	ascular Accident	24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No
5. Was case referred to medical	26. Place of Dea	th Check onl one
art II. Other significant conditions contributing to death but not resulting in the underlying cause given Mu (ti - i fant dementia Cerebral Vascular Accident 5. Was case referred to medical examiner? 1 Yes 20 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
dotormined	28e. Place of injury - At nome, farm, street, factory, onice	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check only 2 Medical Exam	niner: On the basis of examination and/or investigation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

10028324

29d. Date signed (Month, Day, Year)

04/07/09

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. D. 101 COLONIAL Way, Suite A, Dising Sun, MD 21911 E. LATTIN

31. Date filed (Month, Day, Year) APR 0 8 2009

29b. Signature and title of certifier

32. Registrar's Signature

			for State Registrar	State of I	Marylan	-	artmen rtificat			and M	-	giene Reg. No	2000	12737
	Physici	an	1. Decedent's Name (First, Middle, La	est)							2. Date of De Month		ıy_ Year	3. Time of Death
	/Medic		DONALD PAUL								Month MARCH		2009	5:45 P M
	Examin	er	4a. Facility Name (If not institution, give						Location	of Death			. County of Deatl	
- cold			FREDERICK MEMO 5. Social Security Number 6. 9			to a de trade alors d	If Under	EDER	If Under	24 Hre	O. Date of Riv		REDERIC	
п	Funeral			Med M 2□F	80	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Oct 18,	v. Year	Co	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent								JCL 10 ₉	, 19	20 Mary	Tand
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Ba-f sh	ctor	Maryland Freder	ick	Thu	rmont								1 □Yes 2124No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is modical Example and injury or other traumatic event, it is modical Example and injury or other traumatic event, it is modical Example and injury or other traumatic event, it is modical Example and injury or other traumatic event, it is modical Example and injury or other traumatic event, it is modical Example and it is not a first or other traumatic event.	Funeral Director	10e. Street and Number 13608 Winesap Ci	rcle			10f. Zip	Code 1788				-	tizen of What Coi	untry?
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9	after or ite		1 Never Married 2 Married	1 Tes 2			1 ⊟Yes		Specify:		iloan, etc.)		Black, White Specify:	white
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2121	vithin sne. than	E D	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Owner						Ant	omotive	
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anc	d be f	B B	Raymond E. Dou								Fogle	maidei	· oamano,	
Ž	hould nd Me mark matic	욘	19a. Informant's Name/Relationship			10h Mailie	an Addross	/Street				ar City	or Town, State, Z	in Cada)
Maryland	id 2 s Ith ar 27 is 1 trau		Doris Dougherty -	,									Marylan	
ē,	f Hea		20a. Method of Disposition	<u> </u>	20b. F	Place of Dispo cemetery, crei	sition (Nan	ne of	-> !	Da	ate	20c. L	ocation - City or 1	own, State
E O	Pages ent o ht: If i		1 ★Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia			e R i dg				-3-20	009	Thu	rmont, M	aryland
Baltimore,	mit. F partm portar Inju		21. Signature of Funeral Service Lice			_				y Star	uffer I	Fune	ral Home	
ñ	permi Depar Impor any Ir	1 10	ROLLING CON	nilla	61						Thurmo			
		-	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the deat	h. Do not ent	er the mod	le of dying	g, such as	cardiac o	respiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	, u	as a conseq	uence of):	(1 7)	7.						
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9 ×	ding se as	Me	IF FEMALE:	23c. If yes, outcor	me of preama	ancv							224 204 15 44	-
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 ☐ Feta	Ideath 3	☐Ectopic p ☐Other (sp		/			1	23d. Date of deli Month	very Day Year
Ö	the di y the ched	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknow		Jean JE	_Other (sp	ecity)						
σ.	that hed b		Part II. Other significant conditions	contributing to death	n but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco	use contribute to	the cause of death?
Division of Vital Records,	puires n sign lid be	d by	Cardron	YOPat	44						1 🗆 1	Yes 2	No 3□ Pro	obably 4 🗆 Unknown
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>	ysicia s cer direct	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 □	ER/Outpatier	nt 3 🗆 DC	Othe					6 ☐Other (Spec	rify)
0	g Ph er thi	Ë	27. Manner of Death	28a. Date of I (Month,		28b. Time of		8c. Injury Work			8d. Describe I			
<u>o</u>	ndin ath. r: Aft e fun	ație	1 Natural 5 Pending 2 Accident investigatio		Day, rear)	injury	М		.r Yes 2□	No				
Vis	er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not b	28e. Flace of	Injury - At ho	ome, farm, str	eet, factory	office		2	8f. Location (8 City or Tov	Street a	nd Number or Ru	ral Route Number,
	tal or	Certification: To			(,		
	To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 buturs after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only 2 Medical Example 1	nysician: To the be miner: On the basi	st of my kno	wledge, deat	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the	cause(s	s) and manner as d place, and due	stated. to the cause(s)
	the F nin 24 the F nplete	Medical	one)	and manner	stated.									
	vitil Con	2	29b. Signature and title of certifier				290	. License	number			-	ite signed (Month	, <i>uay</i> , rear)
			- Vie	MU			D	> 6	041	7		5-	30-0	7
	6		30. Name and address of person who	completed cause of	of death (Item	n 23a) (Type,	Print)			, ,	- 1			1
		10	Hemen Shal 31. Date filed (Month, Day, Year)	32 Regi	istrar's Signa	mas	JOH	nson	n DI	1-	reder	11.0	K MO	21702
	Sta Registr		ADD (1 6		• Jigila	4 .	hand.	1					1	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Draughn Thomas Craig 1:00 <u>Apri</u>l 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 13585 Sugar Mill Court Waldorf If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 □XM 2 □ F Director 578-84-4668 2/29/1961 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, In. W. dical Event here: ust be redfind a once. 1 ☐Xes 2 ☐ No Funeral Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13585 Sugar Mill Court 20601 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify:Black δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Procurment Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Draughn Virginia Dunn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqulin Draughn/Wife 13585 Sugar Mill Ct. Waldorf, MD. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Gardens 4/10/09 4 Donation 5 Other (Specify) Entombre Waldorf, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Euneral Service Licensee MD0902 <u> 2294 Old Washington Rd. Waldorf, MD. 20601</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oncee **Physician** ON 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐Yes 2 ☐No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J 31. Date filed (Month, Régistrar's Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DAWN 14-09 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 217Th 8. Date of Birth (Month, Day, Year) Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕶 F NEWYORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑No SADENA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: ASIAN 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT HICKS VANITA DOVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANITA DOVE, MOTHER HASADENA, MD. Z1122 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4-15-09 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, MD. 22. Name and Address of Facility DAUGHERTY FUNERAL HOME 21. Signatur f Fund Service Licensee 23a. Part 1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) troke tours Due to (or as a consequence of): hyperters Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed?

1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If them 27 Is marked other than "natural", or items 23a or 3 mortant: If them 27 Is marked other than "natural", or other traumatic event, the Medical Externing Instit La ray

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

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the Maryland

burial-tran attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical ۾ Completed Be Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

23b. Was decedent pregnant 25. Was case referred to medical examiner?
1 Yes 2 □ No 27. Manner of Death 1 Natural

29a. Certifier

(Check only one)

29b. Signature and title of certific

5 Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

and manner stated.

1 Inpatient

. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 117 A Roesler Rd , Clen Burne

State Registrar

Medical

			a POI	•	epartment of F		ental Hygien	e	10710
		_	1 - State Registrar	(Certificate of		Reg. N	10.2009	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)	FST	er	,		2- 2009	9:04 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and nur.			r Location of Death		c. County of Death	100
		1	1166 Appleton Roa		Elk	Ktovi	D. D. J (Disk	Cecil	(0) 1
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 MF	7. Age (In yrs. last birth	rs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea)	9. Birthp Coun	ace (State or Foreign try)
7	2		Usual Residence of Decedent						7 7 0
9	show sd at	'n	10a. State 10b. County	10c. City, Town	. 4			1	0d. Inside City Limits 1 ☐ Yes 2 No
4	28a-f	rect	10e. Street and Number	LIN	10f. Zip Code		10g. (Citizen of What Coun	
de incide	23a or st be	Funeral Director	1166 Appleton Ro	oad		21921		USA	
0	tems termu	uner	11. Marital Status 12. Was Dece Armed Fo	edent Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
000	Il", or i	by F	1 ☐ Never Married 2 Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or Di	/6/	1 ☐ Yes 20 No	Specify:		Specify: Wh	ite
3 A	the William / Z nous arer oean win the maryand that Hydron "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	sted	15. Decedent's Education (Specify only highest grade completed)	16a. I	I Decedent's Usual Occup (Give kind of work done	ation during most of working	16b.	Kind of Business/Inc	lustry
7	han "i han "i e Med	Completed	Elementary/Secondary (0-12) College (1	l-4or 5+)	(Give kind of work done life. DO NOT use retired			Dens base	110
7	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		homemak	18. Mother's Name	(First, Middle, Maid	PWN NOY en Surname)	VIC-
ב ב ב	Mental Mental arked o	To Be	Hartford T. Ger	man		Effic	ALthr	reta	King
	z snould land Mer is marke raumatic		19a. Informant's Name/Relationship (Type. Print	usband) 196.	Mailing Address (Street		Route Number, City	or Town, State, Zip	
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	rages nent of l int: If It		1 ☐ Burial 2 M Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cemetery United	0 1 6	4	, ,	Newark	
	permit. Fages I and 2 should be liled within 72 hours after death with the waryfal pagarfment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Licensee	<u> (U/I) (U</u>	22. Name and Iddre 5+rang + F				/
ם ו	8 8 E 6 8		When Molour	<u> </u>	1635 Churc	chmans k	ood Ne	wark, DE	19702
		S 5	23a. Part1. Enter the disease, of complications that o shock, or heart failure. List only one cause on e Immediate Cause (Final	aused the death. Do no ach line.	ot enter the mode of dyir	ng, such as cardiac or	respiratory arrest,	9	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition	(or as A consequence of	osion in				
E	Examiner			COI	(16				
	sit ed	iner	Sequentially list conditions, if any, leading to him reduct cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of	1	- 1	0		
	al-tran	Examiner	that initiated events resulting in death) Last Due to	(or as a consequence of	10): 3	Joj/(Om			
	cate be executed by sician and the burial-transit	ical	d	Molby	ObesiX				·
00	ing ph		IF FEMALE:	,	/				
ממ	attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	tcome pf pregnancy birth 2 Fetal death nant at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		23d. Date of delive Month	Pry Day Year
j .	oy the ached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		(4,755,7)				
ָה ה	es ma igned l	by P	Part II. Other significant conditions contributing to de	eath but not resulting in	the underlying cause giv	en in Part I.		o use contribute to the	
cords,	requir bould	eted						2 No 3 Prob	
ב ב	ne iaw e has b ge 2 s	Completed					24a. Was an autopsy performed	prior to con death?	psy findings available mpletion of cause of
אונשו	an: I	Be Co	25. Was case referred to medical			26. Place of Death	1□ Yes 2 1 (Check only one)	No 1 □Yes	2 No
> 10	nysici his ce il direc	To B			patient 3 DOA Oth	4 Li Nursing non		6 □Other (Specif	y)
בו כ	After t After t funera		T STANGER S STORY	of Injury 28b. Ti th, Day Year) In	njury Wo	ryat 2 rk? Yes 2 □ No	8d. Describe how in	jury occurred	
VISION	Atten	ficat	3 Suicide 6 Could not be 28e, Place	of Injury - At home, far			8f. Location (Street	and Number or Rura	I Route Number,
5	rs after al Dire	Certification:	4 ☐ Homicide determined buildi	ing, etc. (Specify)			City or Town, St	ate)	
	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the band man	asis of examination and					
	o the	Med	29b. Signature and title of certifier	ner stated.	29c. Licens	se number	29d. I	Date signed (Month,	Day, Year)
,	->=0		> hond	\checkmark	Hill	55071	3	3/17/0	9
	2		30. Name and address of person who completed caus	se of death (Item 23a) (Type, Print)	11. P/	/	Ma	70:11
	Sta	te_	31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	en/MUSV	1/M Rd	CUMON	B 1119	61918
	Registr		APR 0 8 2009 Sever	en B. So	and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Sinia Vernell Exum 17:15PM 4 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Fort Washington P.G. Fort Washington Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 578-38-6191 1 □ M 2 💢 F 96 Director 8-31-1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD P.G. 1 ☐ Yes 2 X No Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13216 Fox Bow Drive #308 20774 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) Domestic College (1-4or 5+) Homemaker d 2 should be filed with and Mental Hygier 7 Is marked other the 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Lewis Johnson Ethel Spaight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #308 19a. Informant's Name/Relationship (Type. Print) Sadie B. Mitchell(Daughter) 13216 Fox Bow Dr. Upper Marlboro MD. 20774 permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-9-2009 Ft. Lincoln Cem. Brentwood MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHunt Funeral Home 908 Kennedy St. N.W. Wash, D.C.20011 21. Signature of Funeral Service Licenses Francis Trunt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumonia wall /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and s the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Records, P.O. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Jas 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2⊠ No 1/ Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: A death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Hospital of 24 hours a To the Hospital within 24 hours at To the Funeral Completely filled in

(8) State

Registrar

Medical

29b. Signature and title of certifier

(Check only one)

Sidanous

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 04-03-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RI HOL HEAStylan ND 20744 N.P 1170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) A Dr 500c DENETTA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dav. Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Months Days 1 M 2 X 1/25/1943 Washington, 66 578-58-5305 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County MXYes 2 No Maryland Prince George's Clinton 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 20735 10619 Thrift Road 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11 Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Yes. Give 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Private 12 Pay Master 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Idola Carter Joseph Edge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10619 Thrift Road Clinton, Maryland 20735 Elliott Rogers / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4/11/2009 Landover, Maryland Harmony Memorial 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest y one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. List only or as a consequence of scleroderma Due to (or as a consequence on) Due to (or as a consequence of) 23d. Date of delivery 23c. If yes, outcome of pregnancy 2 Fetal death Live birth Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examir**

Physician

/Medical

Examiner

10a. State

Director

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permit. Pages 1 and 2.1 Department of Health at Important: If item 27 is any Injury or other trau once.

death with

Pages 1 and 2 should be filed within 72 hours after

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed signed by the attending physician this certificate

death. Director; 24 hours

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 2 1 Yes 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Other: з □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 1 Yes 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No M 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Hospital

Janice Leung 31. Date filed 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

10 State Registrar

31. Date filed (Month, Day, Year) APR 0 8 2009

29b. Signature and title of certifier

Karen Roxanne Brooks, 3001 Hospital Drive, Cheverly, MD 20785 32/ Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0042183

29d. Date signed (Month, Day, Year)

00

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 Physician April 1:45 AM R. Foster Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Dove Hospice House Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F April 15,1934 Pennsylvania 74 Director 86-28-9001 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mydical Eventines is ust be malfined at 1XTYes 2 □ No Director Maryland Carroll Manchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21102 USA 3238 Kensington Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 2 3 x Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Winfred Rose Caroline Baltz Ridgway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 11248 Alton Road, Frederick, MD 21701 Jay H. Foster/ Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr. 7, 2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA all Y 8 E. Ridgeville Blvd, Mt. Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** una -ancer disease or condition resulting in death) /Medical Due to (or as a presequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed J physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical SB attending IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 Ø No Day 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 XNo Physician: 26. Place of Death (Check onl one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural Accident 5 Pending investigation To the Hospitai or within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 wmc rive Westminster 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Barks

09-02639 Clifford A. Forbes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State	Maryland / [Departme <i>Certifica</i>			Mental	Hygiene	Reg. No	. 2	009	127
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Exami		Clifford Alan For	bes					April 3,	2009			'40 hrs
		4a. Facility Name (if not institution, give str	eet and number)		41	o. City, Town, or Lo	cation of De	eath	14	lc. County of I	Death	
		3721 Centre Place				Baltimore						
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date o	f Birth(MN		 Birthplace Foreign 	(State or
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and a smooth of the week of the many in the smooth of the		3721 Centre Place				2122	24			USA		
items 23a or 28a-f sho ust be notified at once.	uneral		. Was Decedent Ev Armed Forces?	ver in U.S.		Decedent of Hispa es, specify Cuban, I				14. Race - White,	American In etc.	dian, Black,
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piene.	Completed	11 17. Father's Name (First, Middle, Last)					R Mother's N	ame (First, Midd	ile Maide		DCTAC	
dental Hygiene. narked other than "natural", or itc event, the Medical Examiner must	Be C	John J. Forbes						ia J. E				
ent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", r other traumatic event, the Medical Examiner	To B	19a. Informant's Name/Relationship (Type	. Print)	19	b. Mailing	Address (Street		-			State, Zip (Code)
27 is matic	-	Gloria Lowe/sister				Sherri's		Smithsb			1783	
nt of Health and N nt: If item 27 is n other traumatic		20a. Method of Disposition			of Disposi	tion (Name of ceme		Date	200	c. Location - C	City or Town	State
t of t		1 Burial 2 X Cremation 3	Removal from State		ory or oth	er place) remation,	Tnc	1/6/20	na	Hampst	ead. I	ΜD
rtant rtant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Carro	_							- LUI
Department of Important:		A will have service Licensee			Pr	itts Fund 2 Washing	eral' H	lome and	Cha	pel, P	·A.	21157
/sician		23a. Part I. Enter the disease or complicate failure. List only one cause on each I	tions that caused th	e death. Do n	ot enter th	e mode of dying, s	uch as cardi	iac or respirator	y arrest, s	shock, or hear	t Ap	proximate Interva
ledical		1.1.	_{ine.} Dipneni pertensive Ath	nyaram:	ine 1	ntoxicat	ion ai	na			Be	tween Onset and Death
aminer			to (or as a conseq		Calul	Jvasculai Dise						
		Sequentially list conditions, b		_								
	ner	if any, leading to immediate Due	to (or as a conseq	uence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a conseq	uence of):								
and rransit	Ĕ	events resulting in death) Last Due	, (o (o) as a bonsoq	201100 017.								
sician and	edical	UNPENDED X A	MENDED 23	a,27,28	Ba-f,	perME, g	891 5/	/15/09 1	T			
sici	Med		23c. If yes, outcome	of pregnancy						23d. Date of c	lelivery	
nding phy se as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	,		tal death 3	Ectopic pr	egnancy		Month	Day	Year
ttend	Sici	A Ver of Ne of Universe 4	4 Pregnant at ti	me of death	5 Oth	ner (Specify)			_			
	چّ		9 Unknown	hut ant socultie	a in the u	ndorlying course si	von in Part I	23e	Did tobac	co use contrib	oute to the c	ause of death?
y the a	by	Part II. Other significant conditions co	numbuting to death t	but not resulti	ig iii tile u	ndenying cause gr	verilirraiti		-			4 V Unknown
ned by the a detached fo	9	Chronic alcohol abuse					-		Was an			findings availab
n signed by the a	9								autopsy performed	рг	rior to compleath?	etion of cause of
as been signed by the attending phy should be detached for use as the l	plete										✓ Yes	2 No
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2 23	te Completed	25. Was case referred to medical						neck only one)	163 2	140		
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Toyphal or Attending Thysician. The far 24 hours after death. Functal Director: After this certificate ha tely filled in by the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 X Could not be determined 29a. Certifier 1 Certifying Physician: one) 2 Medical Examiner: Or	28a. Date of Injury (Month, Day, Yee Fd 4/3/(28e. Place of Inju (Specify) To the best of my	28b. 09 Fc iry - At home, touse	Time of It	3 DOA on injury 28c. Injury 28c. Injury 28c. Injury 1 To you are to the time, data ion, in my opinion,	Other Note 1 Not	lursing Home 28d. Desc unk 28f. Local or To Ball	Respondence of the control of the co	injury occurre et and Numbe) 3721 e. MD and manner place, and du	or or Rural R Centr as stated.	oute Number, Cite Place
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Toyphal or Attending Thysician. The far 24 hours after death. Functal Director: After this certificate ha tely filled in by the funeral director, page 2	Certification: To Be	examiner? 1 V Yes 2 No 27. Manner of Death 1 V Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: Or an 29b. Signature and title of certifier August Suddens Sof person who come	28a. Date of Injury (Month, Day, Yes Fd 4/3/0 28e. Place of Injury (Specify) To the best of my on the basis of examind manner stated.	y 28b. 28b. 28b. 27 - At home, 1 00 Se knowledge, de ination and/or ath (Item 23a)	Time of II 1 5:2 iarm, stree eath occur investigat	3 DOA njury 28c. Injury O pm 1 Y et, factory, office but red at the time, dat ion, in my opinion, 29c. License	obther N y at Work? es 2 X No uilding, etc. te and place death occur e number 1.E.	lursing Home : 28d. Desc 28d. Desc 28f. Local or To Balt a, and due to the rred at the time,	Respondence of the control of the co	injury occurre et and Numbe) 3721 e. MD and manner place, and du dd. Date signe	r or Rural R Centr as stated. ue to the cau	oute Number, Cit e Place

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 3, 2009 **Physician** Robert H. Fuhrman 1:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6 Summer Hill Trailer Park Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1071271943 Hours Min. 1 X M 2 □ F Connecticut 65 263 68 6623 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Mulcal Examiner must be notified at MD 1 ☐ Yes 2 TXNo Anne Arundel Crownsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 Summer Hill Trailer Park 21032 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | No
If Yes, Give
Year or Dates:

12. Was Decedent Ever in U.S.
13. The control of the 13. Was Decedent of Hispanic Origin? (Specify Yes or No-m If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify: White ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Robert H. Fuhrman Jr. Annette Duschene ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Smith (Executor) Summer Hill Trailer Park, Crownsville MD 21032 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 4/6/09 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Advent Funeral and Cremation Services Annapolis MD and Falls Church VA 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician 3/4 na disease or condition resulting in death) /Medical Due to (or as a connequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are utilized to the control of the contro Due to (or as a consequence of). Examiner executed burial-trans resulting in death) Last Due to (or as a consequence of): physician a P.O. Box 68760. certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performeç death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records. of Vital Division

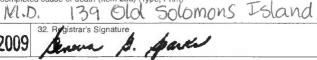
State

ERICA BENNS 31. Date filed (Month, Day, Year) APR 06

29b. Signature and title of certifi

29a. Certifier

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** FORD E. **JAMES** РМ 2009 2:00 APRIL /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 M 2□F 577-42-0016 75 WASHINGTON, DC Director AUG. 16 1933 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director PRINCE GEORGE'S FORESTVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA 7420 MARLBORO PIKE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 10 Pear or Dates: 1950/1955 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. BLACK Specify: Completed by 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 11THBUS DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TILLEY MYRTLE CHARLES FORD ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 BRINKLEY RD # 302 TEMPLE HILLS, MARYLAND 20748 DONALD M. FORD/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEME 4/14/09 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility J. B. JENKINS FUNEPAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aspiranon Physician mount. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş pe 20 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was autopsy performed? this certificate 2 **1**00 1 ☐ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide

Hospital

To the

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of or

زالغ

39 Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

1328 Souther avenu SE Suit 310

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ž Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0055120

29d. Date signed (Month, Day, Year)

Washington

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Louis 1205 PM 31 2009 Gorin March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5802 Nicholson Lane, Apt. L07 Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year) 1**X** M 2 □ F 91 May 9, 1917 **Director** 579-22-1857 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits IT is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exercity of round by notified at Director 1 XYes 2 No Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 5802 Nicholson Lane, Apt. L07 20852 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc Armed Forces 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify þ 3 ™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 1 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other transmitted. 0wner Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Gorin Gussie "unascertainable" 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven M. Gorin, son 17 Old Orchard Lane, Trumbull, $_{\rm CN}$ 06611 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Memorial
Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/03/2009 | Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Gonald C. MO0564 1091 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, learning to introductions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed Bronchiectasis and Due to (or as a consequence of) burial-Box 68760, attending physician Physician/Medical Coronary Artery Disease the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 5 ☐ Other (specify) □Yes 2 □ No P.O. the detached 9 I Inknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Diabetes cate has been si page 2 should b 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 1 LXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Affolietely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ D14111 April 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome S. Putnam, MD 5530 Wisconsin Avenue, #800 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 08 Registrar

09-02541 Dean Gordan	Please Type or Print in Black Indelit State of Maryland / Departme	·	_				
Dean Cordan	1- For State Certifica	ate of Death	Reg. No. 2 1 1	9 1271			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death			
Medical Examine	DEMIT GORDON		March 30, 2009	2300 hrs			
1	Prince Georges Hospital	4b. City, Town, or Location of Death Cheverly	4c. County of Death Prince George's				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		. 8. Date of Birth (MM/DD/YYYY) 9. Birth	thplace (State or Foreign			
Director	$\begin{bmatrix} 577 - 80 - 0532 \\ 1 \end{bmatrix}$ $\begin{bmatrix} X \\ D \end{bmatrix}$ $\begin{bmatrix} 2 \\ D \end{bmatrix}$ $\begin{bmatrix} 51 \\ \end{bmatrix}$	Yrs. Months Days Hours Min.		untry) DC SHINGTON			
	Usual Residence of Decedent		111/0/1937 11/11				
w any	10a. State 10b. County 10c. City, Town of the City of			10d. Inside City Limits 1 X Yes 2 No			
yland yland tonce	DC WASHIN	GTON 10f. Zip Code	10g. Citizen of What Country?				
in the Maryland 13a or 28a-f sh inotified at one	105 35th St., N.E.#3	20019		UNITED STATES			
death with the Maryland or items 23a or 28a-f show must be notified at once		13. Was Decedent of Hispanic Origin? (Sp	Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,				
or items 23 in must be no	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto					
s after ral", o	Widowed 4 Divorced in res, Give rear or Dates:	1 Yes 2 X No specify:	specify: BLA				
"natu		Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		illoustry			
5-0036 ed within 72 hour lygiene. other than "nature he Medical Exau	. 12th M	ETER MAN	PRIVATE				
5-0(led wi Hygier I other			(First, Middle, Maiden Surname)	,			
1121 Id be fill dental larked event,		DOROTH 1	Y MARTIN	Zin Code)			
LD 21 2 should and Me 27 is ma matic ev		2.4 35th St. N.E.	WASHINGTON D	C 20019			
e, N 1 and 2 Health item 3	20a. Method of Disposition 20b. Place of	ory or other place)	Date 20c. Location - City or				
mor Pages ent of ent of r other	1 X Burial 2 Cremation 3 Removal from State CEDAR	. MD.					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient in 22 hours after death with the Maryland Important: If then 7 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commissed by Funeral Director	21. Signature of Funeral State Operation	22. Name and Address of Facility CAI	PITOL MORTUARY				
	23. Part I, Enter the dis lark, or complications that caused the diagni Do no	I 1/25 MARVIAND A	VVE NE WACH	D.C. 2000 Approximate Interval			
Physician /Medical	failure. List only one cause on each line.		Trespiratory arrest, shock, or fleat	Between Onset and Death			
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Narcotic (heroin) Due to (or as a consequence of):) intoxication					
, I	Sequentially list conditions, b						
ed msit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
sit d	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
executed ian and ial - transit		ed, 23a,27,28a-f,per	ME, g890 4/22/09 T				
50, te be e ysicia buria	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	v			
68760, certificate be ading physici se as the buri	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna	ancy Month	Day Year			
). Box 68760, the death certificate be early the attending physicis cled for use as the burish Dhyscin and Madi	4 Pregnant at time of death 1 Yes 2 No 9 Unknown	Other (Specify)					
O. B. hat the de ed by the letached f		g in the underlying cause given in Part I.	23e, Did tobacco use contribute to	the cause of death?			
ires that signed libe deta			1 Yes 2 No 3 Pro	bably 4 Unknown			
cords, law requir has been s 2 should l			autopsy prior to	utopsy findings available completion of cause of			
Records, The law requires ficate has been sig			performed? death? 1 Yes 2 No 1 Y	es 2 No			
Division of Vital Records, P. Ital or Attending Physician: The law requires the 1st after death. All Director: After this certificate has been signe ted in by the funeral director, page 2 should be districted by the funeral director, page 2 should be districted by the funeral director.	25. Was case referred to medical	26.Place of Death (Check					
f Vit	1 V Yes 2 No 1 Inpatient 2 V ER/O	utpatient 3 DOA Other Wursin Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Othe	er: 			
on of anding Ph. th. r: After the funeral	1 Natural 5 Pending 2 (30 (00	1 Yes 2 X No	unk				
ivision I or Attendi after death. Director: d in by the f	2 Accident Investigation 3/30/09 un 3 Suicide 6 XCould not be		28f. Location (Street and Number or R	ural Route Number, City			
Division o spital or Attending tours after death neral Director: After filled in by the fune	4 Homicide determined (Specify) Home		28f. Location (Street and Number of Re or Town, State) 1 2 4 35 th Washington, DC	ot, NE			
the Ho hin 24 I the Fu opletely							
HA 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Day, Year)			
	(Carloberty)	O.C.M.E.	April 1, 2009				
4	30. Name and address of person who completed cause of death (Item 23a)	4 Dann Chrock Delking MD 040	201				
		1 Penn Street, Baltimore, MD 212	201				
Stat Registra		gale					
DHMH 17 Rev 1/200	OF	RIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#20 openFH4/6/09, BWI, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 09 HOT /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Monta onev Social Security Number 08 V9. Birthplace (State or Foreign Country) N • Y • , N • Y • 8. Date of Birth (Month, Day, vrs. last birthday) **Funeral** 23018 Months Days Hours Min 8 939 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. Count 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20887 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Extes 2 No 1942 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 2/10 Specify: Wite 1 ☐ Yes Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the 34 and 50 a Elementary/Secondary (0-12) College (1-4or 5+) 12 Gasoline Stations Owner/Operator Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Gelman Sarah Konigsberg ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Gelman/Son 21509 Goshens Edge Court Gaithersburg, Md 2088 Date 20c. Location - City or Town, State Clinton, CT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Femoval from State 4 Donation S Other (Specify) Beave Brook Cem. 22. Name and Address of Facility 43 Kirkham Ave. East Haven, CT. 21. Signature SISK Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Desits for as a consequence of that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 Unknown ٣. 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementa Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy performe certificate 2 Z No 1 ☐Yes 2 ☐ No 1 □ Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manne of Death 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural n 24 hours after death.

Ne Funeral Director: A

pletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 Delord 31281 1+0065661 te 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 8101 Prince Philip Dr. Olney, Md 20832 Debroh Stew, D.O. Montgomen General Philip Dr. Olney, Md 20832 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** April 4, 2009 9:20 A M MARY S. GREENWELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crofton Convalescent & Rehab Crofton 9. Birthplace (State or Foreign Country) Georgia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day April 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Year) 1 M 2 F 79 1929 Yrs. 579-40-5774 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Exercises counts to confiled at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Prince George's 1 ☐ Yes 2 No Maryland Forestville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7910 Daniel Drive 20747 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: þ White 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary C & P Telephone Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Vernon Stephens Virginia Godbee ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Julia Greenwell / Daughter 7910 Daniel Drive Forestville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 04/08/2009 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** menti disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy In the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2. No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 NO 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 ☐ Pending ours after death. heral Director: Af filled in by the fut 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

6

#222 Bowie, Maryland

20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 Gallant Fox Lane

32. Registrar's Signature

MD

Rakesh Arora

			For State	State of Ma	aryland		artment of H		and Me	_		2000	12752	
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of I			Heg. No.			
	Physicia	an								Month Day			6:40p M	
4	/Medic		A Solith Name (Keet institution with a treat and number) A Solith Name (Keet institution with a treat and number)								County of De			
	Examin	er	Laurel Regional Hospital				Laurel					rince George's		
andr	Francis		5. Social Security Number 6. Sec		e (In yrs. la:	st birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	B. Date of Bir (Month, Da			rthplace (State or Foreign Country)	
н	Funeral Director]M 2□F	66	Yrs.	Months Days	Hours		Month, Da 2 / 2 1 / 1			ennsylvania	
			Usual Residence of Decedent											
	how how	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits	
	Ba-f s	cto	Maryland Anne Arundel Jessup								1 ∏ Yes 2 □ No			
	er death with th	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What (Country?	
				7500 Glen Eagle Drive					20794					
		Funeral	11. Wallal States	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)			-	 Race - An Black, Wh 	nerican Indian, ite, etc.	
36	s afte	Σ.	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:									Specify: White		
8	hour tural	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation								16b. Ki	. Kind of Business/Industry		
15	in 72 r "na redic	plet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) [College (1-4or 5+)]						of working	7			•	
212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	E	12	College (1-4015	+)	Pı	inter				True	tone P	ress, Inc.	
٦		To Be C	17. Father's Name (First, Middle, Last)	 "	_			18. Mothe	r's Name (First, Middle,			•	
Maryland 21215-0036			William August Doroth							ia Mae O'Conner				
ar			19a. Informant's Name/Relationship (Ty				ng Address (Street				-		, Zip Code)	
≥.	and		Lorraine E. Hower	- Wife			Glen Eag					20794		
ore	permit. Pages 1 Department of H Important: If itee any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	Removal from State	1		sition (Name of natory or other place		Da			•	or Town, State	
altimore,			4□Donation 5□Other (Specify) Fort Lincoln Crem						<u> </u>			Brentwood, MD		
Ba			21. Signature of Futeral Servic Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722											
	Physician		23a. Part 1. Enter the disease, or compl	ications that caused	the death.							-	Approximate Interval Between	
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acute Myocardial Infarction									Onset and Death		
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):										
	Examiner		Sequentially list conditions,	Renal Failure										
		ine	cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes Mellitus										
_	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	S	Due to (or as a consequence of):									
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687	ficate g phys s the	edical		J										
	eath certific attending p for use as	N/N	IF FEMALE: 23c. If yes, outcome of pregnancy									23d. Date of delivery		
P.O. Box	death e atte d for	sician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic pregnanc ☐ Other (spec <i>ify</i>)	у				Month Day Year		
0	that the dened by the a	by Phys	9 Unknown							_				
S,	gned gned		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of d			to the cause of death?	
D'C	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	ed									1 ☐ Yes 2 ☐ No 3 ☐ Probably 4万 Unknown			
ecc		ple								24a. Was an autopsy findings av prior to completion of cau			autopsy findings available o completion of cause of	
<u>س</u>		Completed								performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			?	
/ita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Be (25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
<u></u>			1 10 10 2 2 10 10	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
UC.		jon	27. Manner of Death 1 X Natural 5 ☐ Pending	(Month, Day, Year) Injury Work?						28d. Describe how injury occurred				
is:		ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	De 280 Place of Injury. At home farm street factory office					28f. Location (Street and Number or Rural Route Number,					
Division of Vital Records,		Certification: To	4 ☐ Homicide determined	building, etc. (Specify)					City or Town, State)					
	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in 1	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
4	To the He within 24 To the Fu									29d. Da	9d. Date signed (Month, Day, Year)			
	- > - 0)	THO	e	MS	D24	721			4/2	2/2009		
	5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								20700				
			Syed A. Dadiq, MD 14333 Laurel Bowie Road, Ste 208, Laurel MD 20708											
	Sta Registr		31. Date filed (Month Day 77) 2005	2. Registr	ars signal.	pe for	Kel							

For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No./

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** WILLIAM HUSSONG, JR. APRIL 4, 12:54P M J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 17 M 2 □ F 91 157-05-2156 Director JULY 17,1917 NEW JERSEY Usual Residence of Decedent 10a State 10b. County 10c City Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examination retitled at MD. MONTGOMERY Director ROCKVILLE No Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9519 VEIRS DRIVE (2)20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X□Yes 2□No
If Yes, Give
Year or Dates 1942-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Paues 1 and 2 should be filed within 72 hours after (
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or iter
any injury or other traumatic event, Item sitel Emerical 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ♥☐ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S.NAVAL OFFICER U.S. NAVY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM J. HUSSONG LILLIAN BENTLEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE HUSSONG- WIFE 9519-VEIRS DR #2 ROCKVILLE, MD. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY-4/11/09-ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW 21. Signature of Funeral Sec HYSONG CO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Dysrrthmia /Medical Due to (or as a consequence of): Examiner Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy certificate 1 □Yes 2X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭XNo ဥ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Attending Physician: To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

the Maryland

death with

Baltimore, Maryland 21215-0036

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Dr., Rockville, Md. MCQUIS TON

31. Date filed /Mo

and manner stated

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

)00 628 3 9

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:05 a M April 2009 Francis M. Hohl 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 X M 2 □ F 76 169-26-8440 March 13, 1933 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21811 10424 Dinges Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Perdue Farms, Inc. 12th Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Koch Katie Hohl Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10424 Dinges Road - Berlin, Maryland 21811 Anna Hohl/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 104/04/2009 4 ☐ Dørnation 5 ☐ Other (Specify) Salisbury, Maryland Salisbury Crematory 2f. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one on seion each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) e to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

1 Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mangon injury or other traumatic event, the Mangones.

Maryland

Baltimore,

000

0 000 **Physician**

/Medical

Examiner

10a. State

Funeral

Director

ms 23a or 28a-f show

Funeral Director

Be Completed by

2

ate has baan signed by the attending physician and page 2 should be detached for use as the burial-transit

Records, Physician: Tha law of Vital Franc1 Division or Attending after death. within 24 hours a

To the Funeral D Hospital To the

Examiner Be Completed by Physician/Medical Medical Certification: To the

25. Was case referred to medical examiner?

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

30. Name and address of person

Hospital:

5 Pending investigation

6 Could not be

Year,

APR II 7

1 ☐ Inpatient

28a. Date of Injury (Month, Day, Year)

completely State

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

mpleted cause of death (Item 23a) (Type Frint)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 3, 2009 12:17P.M Richard Jones /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Sept. 5, 1930 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral X** M 2□ F Min. Months Days Hours 217-44-0782 78 Washington, DC **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Madical Examinar must be notified a once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Director Beltsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11708 Pine Street 20705 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 (2)Yes 2 □ No If Yes, Give Year or Dates: 1953-1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. ģ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician U.S.D.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) Nettie Jones မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7118 Ducketts Lane,#201 Elkridge, Maryland 21075 Holly Roach -Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4/8/2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 01 disease or condition resulting in death) M /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No icate has been sig , page 2 should b 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 (No Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 29c. License number +1 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring

State

Registrar

31. Date filed (Month, Day,

Year)

06

artes

Registrar's Signature

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 275	5 7
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) TACK E JACKSON 2. Date of Death Month O 3 2007 1: 20 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death	
Funeral Director		LORIEN MT AIR1 5. Social Security Number 234-82-7990 6. Sex 5. Second Security Number 234-82-7990 1	'eign
21215-0036 d within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lir Maryland Frederick Mt. Airy 10e. Street and Number 4292 Molesworth Terrace 11. Marital Status 1	
Maryland nd 2 should be file alth and Mental Hy 27 is marked oth	To Be C	17. Father's Name (First, Middle, Last) Guy Thacker Jackson 18. Mother's Name (First, Middle, Maiden Surname) Jean Viola Wolfe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Jackson/Wife 4292 Molesworth Terrace Mt. Airy, MD 21771 20a. Method of Disposition 10 Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	
Baltimore, permit. Pages 1 a Department of Her Important: If item any injury or othe		Stauffer Crematory 4/7/2009 Frederick,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 8 E. Ridgeville Blvd. Mt. Airy, MD 21771	
B760, ate be executed hysician and hysician and the burial-transit	ical Examiner	23a Part Injury the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. The LOSION Due (or as a consequence of): Due (or as a consequence of): Due (or as a consequence of): C. The LOSION Due (or as a consequence of):	
Box 6 death certific e attending p d for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	
I Records, P.O The law requires that the tens been signed by the page 2 should be detache	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings availated to the cause of death 25b. No 3 Probably 4 Unknown 24b. Were autopsy findings availated to the cause of death 25b. Were autopsy findin	own able
	To Be Com	autopsy performed? 1 Test 2 No 25 Was case referred to medical examiner? 1 Test 2 No 26 Place of Death Check onlone 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Noursing Home 5 Residence 6 Other (Specify)	OT
VISION Attending r death. ector: Afte by the fune	Certification:	27. Manner of Death 1 Natural S Pending investigation S Coldent S Coldent	
To the Hospital or within 24 hours after within 24 hours after To the Funeral Director completely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	9
Sta Regist		30 Name and address of person who completed cause of death (Item 23a) Type-Print) House Ave, J-1, Freederick Mdz 31. Date filed (Month, Day, Year) 32. Registrar's Signature	170

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death Month Menth 1. Decedent's Name (First, Middle, Last) **Physician** Jones Lewis 2009 char /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, ox Location of Death 4c. County of Death **Examiner** SIZY EXONUS montecopier PC Ker96UT 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1X M 2 F 326-22-0010 81 Yrs. 1927 Illinois Director July Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner over the notified at 1 ☐ Yes 2 No Md. Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 8124 Exodus Drive United States Items 23e Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1⊠Yes 2⊡No WWII IfYes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🛛 No Specify: <u>م</u> 3 Widowed 4 Divorced White ear or Dates: Korean "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than ' College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. 12 Engineer U.S. Government other should be fin lith and Mental Hv 7 is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mabel Olean Risting Reese Jones Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 is Mary Ann Jones / Wife 8124 Exodus Drive, Gaithersburg, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ited 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 Other (Specify) Metropolitan Crem. 4/7/09 Alexandria, Va. 21. Sign ture of Funeral Saving Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home en, Box 5038, Laytonsville, 209 P. O. 20882 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 20m 51 disease or condition つつ /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cases. Error underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as the IF FEMALE: nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death Jo Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Ö detached 9 Unknown 9 Unknown ģ Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 0 re 99100 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cancer has page 2 autopsy performed? certificate 1 🗌 Yes 2 A No 1 ☐ Yes 2 ☐ No of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 X Yes 2 □ No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division After Attending 5 Pending Injury 1 Natural 1100 - Inslickey death. 5 2009 1 ☐ Yes 2 ☑ No Un 9hz To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident investigation pr 6 Could not be determined 281. Location (Street and Number or Rural Route Number, Dr. City or Town, State) 124 Exolv5 Dr. Carlesoure mb 2088 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Wome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Don4 m Dmg đ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8+1 EZ

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Pa

32 Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 2, Physician 2009 Richard L. Jaquith 1835 p. м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 7, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Hours Days 62 1 3kM 2 ☐ F 215-46-1387 Connecticut Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eva miner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Frederick Ijamsville Maryland 1 TYes X No Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21754 10140 Greenward Link USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 2 No 1 □Yes XXNo white Specify. þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Special Forces U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard H. Jaquith Emma L. Bottum မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Huber wife 10140 Greenward Link, Ijamsville, Maryland 21754 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4-22-2009 Arlington National Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home Ollug 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, -- complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cirrhosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Jaundice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Alcohol Abuse resulting in death) Last Due to (or as a consequence of): Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Acute renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □ Yes 2 🗆 No 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

20+1

Santosh Rane, M.D.

29b. Signature and title of certifier

29a. Certifier

Medical

State Registrar RANE, MD

0 68178

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

9901 Medical Center Drive, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 APRIL 9:52 A M JONES CARLTON Т. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 18 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 1**X**□ M 2□ F VIRGINIA 1952 Director 56 229-74-3734 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show oficial Examiner must be notified at 1 Yes 2 No SUITLAND PRINCE GEORGE'S Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20746 Funeral 6108 SKYLINE TERRACE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □XYes / 2 □ No ARMY If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 ☐ No 9 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12TH MANAGER is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental FLORA E. USUAL ELIJAH JACOB JONES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6108 SKYLINE TERRACE SUITLAND, MARYLAND 20746 : If item 27 is or other tra THERESA JONES/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages ' ₽ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4/8/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 Donation 5 Dother (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility meral Service Lice se 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, is admig to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 No 24a. Was an has page 2 autopsy certificate 1 Tes or Attending Physician: ours after death.

Neral Director: After this certific
filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. Records, Division of Vital

Baltimore, Maryland 21215-0036

Hospital 24 hours a To the within 2 To the

Registrar

completely

Medical

29a. Certifier

State

30. Name and addre

29b. Signature and title of contifie

who completed cause of death (Item 23a) (Type, Print)

and manner stated

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date şigned (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician 2009** P^{M} 2 4:45 APR JOHN GEORGE KNAPP /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, DEC 21, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 XM 2□ F 1947 Connecticut 61 Director 045-36-1586 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County ns 23a or 28a-f show 1 □Yes 2 No Director Burke Virginia Fairfax 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 22015 United States 6101 Lundy Place Funeral and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 □ № 71
If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or items 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 1971 If Yes, Give 1971 Year or Dates: 1993 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Lieutenant Colonel U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Dorothy Chowanec Knapp John J. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i 6101 Lundy Place, Burke, Virginia 22015 Ginette Knapp / wife other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; If ite
any Injury or ot
once. 1 XBurial 2 ☐ Cremation 3 X Removal from State Quantico National Cem 04/19/2009 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fyneral Service Fairfax Memorial Funeral Home M00956 9902 Braddock Road, Fairfax, Virginia 22032 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in reduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t irector, page 2 s autopsy performed: 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Director: Ailed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral D completely filled i the P

29a, Certifier

29b. Signature and title of certifier

Medical

State Registrar 31. Date filed (Month): Dav. Year) LT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0101242364 (VA)

NATIONAL NAVAL MEDÍCAL BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

			State of Maryland	-	artment of H			711119	12762
			Registrar 1. Decedent's Name (First, Middle, Last)		lilicate of I		2. Date of Death	3,,,,,	3. Time of Death
	Physicia						Month March	Day Year 2009	10:15 P M
	/Medic Examin		Ann Katzenbach 4a. Facility Name (If not institution, give street and number)	-	4b. City, Town, or	Location of Death	Haren	4c. County of Deat	
			Arcola Nursing Home		Silve	r Spring		Montgome	ery
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director		218-38-6397 68 Usual Residence of Decedent	Yrs.			Nov. 14,	1940 Unl	cnown
	land ow			Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgomery S:	ilver	Spring				1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evening must be notified at		801 Arcola Avenue		209			United	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexic <i>a</i> n, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
35	I', or	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	I□Yes 2⊠No	Specify:		Specify: W	hite
9500-6121	2 hou		15. Decedent's Education	16a. Deced	lent's Usual Occup	ation		6b. Kind of Business/	Industry
Ž	thin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT use retired	furing most of work i)	ing		
N	filed within Hygiene. other than "		12	No	one		(F) 1.04:111 A	None	
land	be fill	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	_	
Ĕ	permit. Pages 1 and 2 should be fi Department of Health and Menna! I Important: If item 27 is marked of any Injury or other traumatic ever any Injury or other traumatic ever	၉	Herbert Katzenbach 19a, Informant's Name/Relationship (Type, Print)	19h Mailin	ng Address (Street	Helen	al Route Number	Lang City or Town, State, 2	Zip Code)
Z	nd 2 s lith an 27 is r trau							, MD 20850	
saltimore,	s 1 ar if Hea item		20a. Method of Disposition 20b. Plan		sition (Name of natory or other place			0c. Location - City or	
Ê	Page: nent o int: If		1 Buriai 2 EN Cremation 3 Li Removal from State 1			tory 4/10	/2009	Brentwood,	MD
a	rmit. partm porta y Inju		21. Signature Funeral Service Licensee	22	. Name and Addre	ss of Facility Sin	ple Trib		
מ	8 8 2 2 8		elps	10	040 Rockv	ille Pike	, Rockvi	.11e, MD 20	0852
			23a. Part 1. Enter the dilease, or complications that caused the death. shock, or heart falure. List only one cause on each line.	Do not ente	er the mode of dyir	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
1	Physician		Immediate Cause (First disease or condition Osteomyelitis						Onset and Death 1 year
	/Medical Examiner		resulting in death) Due to (or as a consequence)	nce of):					
		Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque)	nce of):					
,	uted d ansit	Examiner	Cause (Disease or injury						
5	an andrial-tra		that initiated events resulting in death) Last C. Due to (or as a consequent	nce of):					
8/60,	death certificate be executed e attending physician and d for use as the burial-transit	dical	d						
õ	ertific ling pl	Med	IF FEMALE:						
ğ	alcian: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?	eath 3	Ectopic pregnanc	y		23d. Date of del Month	ivery D <i>a</i> y Ye <i>a</i> r
o	the de	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown 9 ☐ Unknown	an 5L	Other (specify)				
<u>. </u>	requires that the	₾	Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ras	quires n sign ald be	d by					1 ☐ Yes	s 2⊠No 3⊟Pr	obably 4 Unknown
ecord	law red as bee 2 shou	Completed					24a. Was an	24b. Were au	topsy findings available
ř	The Ist	E					autopsy perform 1 □ Yes 2	ed? death?	completion of cause of 2 □ No
	sian: artifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one		
> 	Physician: r this certifica ral director, p		1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpatient 2 ☐ El			4 EM Nursing no		nce 6 Other (Spe	cify)
<u></u>	ling F	Ö	1 Natural 5 Pending (Month, Day, Year)	8b. Time of Injury	Worl		28d. Describe how	w injury occurred	
VISION	death death stor: / the 1	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - 4t hom	e farm str		Yes 2 □No	28f Location /Str	eet and Number or Ru	iral Route Number
\geq	lor A after Direc	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	o, idim, otiv	oot, lactory, office		City or Town,		narrioute ramooi,
	spita nours neral y filled		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowl						
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: On the basis of examination one) and manner stated.	on and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To ti withi To ti	Ž	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
	V		Mal Kapeal		D09	834		3/27/2009)
			30. Name and address of person who completed cause of death (Item 2			•	MD 0000		
	Sto		Barry Rosenbaum 3720 Farragi 31. Date filed (Month, Day, Year) 33 Registrar's Signatur	re		sington,	MD 2089	כי	_
	Sta Registra		APR 06 2009 Leters B.	back	KI				
				17					

Τ.

KIRWIN

For State Registral

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

MARGARET

6 Could not be

SISIC

2009

determined

PRACTITIONER and manner stated.

3 Suicide

29a. Certifier

4 Homicide

one)N.

29b. Signature and title of ce

30. Name and address of p

ANNA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 17 & 18 per Inf C896 10/21/09 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

Reg. No.

Day

4,

Year

2009

4c. County of Death

3. Time of Death

2:00 P M

2. Date of Death

Month

APRIL

MONTGOMERY Birthplace (State or Foreign Country) MARCH 1,1916 ILLINOIS 10d. Inside City Limits 1 TYes 2 ☐ No 10g. Citizen of What Country? U.S.A. Race - American Indian, Black, White, etc. WHITE 16b. Kind of Business/Industry NURSING ₽. MILLARD 20740 20c. Location - City or Town, State RIVERDALE, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 💢 No 1 ☐ Yes 2 🗆 No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) SISTED 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 No extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) PRIL 6. 2009 3140 GRACEFIELD RD., SILVER SPRING. MD .

Registrar

State

R151342

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

rson who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral D

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2009 APRIL 1 4:11 A^{M} VIOLA WILHELMINA KELLY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Aug. 21, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🔀 F 89 Maryland **Director** 213-30-5555 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show 10a. State No Yes 2 No Funeral Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9263 Cartersville Road 21046 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married 21215-0036 1 ∐Yes 2 XXNo Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7th Domestic Home Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) yes 1 and 2 should be fill to the alth and Mental H If item 27 is marked other traumatic evening the stream of the Mary Elizabeth Bentley William Henry Kelly ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 4 6 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n amy Injury or other traur Harriett V. Carter (Daughter) 7348 Oakland Mills Rd, Columbia, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from 1 ☐ Burja 2 ☐ Cremation MD Nat'l Mem Park 4/7/09 Laurel, MD 4 ☐ Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. alure of Funeral Service 6|246 N. Washington St,Rockville,MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sudden disease or condition resulting in death) Intracerebral Hemorrhage /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical use as Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar signed by the a 5 Other (specify) 1 ☐ Yes 2 ☑ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardiomyopathy 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Diabetes Mellitus of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1X Natural ours after death.

eral Director: Al filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/01/09 D32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D. 9801 Georgia Ave, #220, Silver Spring, MD 20902

State Registrar 31. Date filed (Month, Day, Year)

22. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** ALICE MAE KELLY 31, 2009 10:30A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital MONTGOMERY Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar.19,19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🖫 F Maryland 70 ,1939 218-38-5530 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at ty Yes 2 □ No Director MD Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 21000 Father Hurley Blve, #112 20874 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 💥 No Specify: Specify: Black 3 ☐ Widowed 4 € Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nursing Assistant 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Menta Alice E. Thomas Richard E. Davis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Emily L. Mason (Sister) 14771 Sugarland Road, Poolesville, MD 20837 permit. Pages 1 a
Department of Hei
Important: If item
any injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 27 Cremation 3 Removal from Paul Church Cem 4/8/09 Poolesville,MD 5 ☐ Other (Specify) 4 ☐ Donagion 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a Part 1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cardiac Pulmonary Arrest /Medical Due to (or as a consequence of): Examiner Advanced Breast Cancer with Metastasis Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 1 ☐ Yes 2 ☐ No 1 □ Yes 2√2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ ₩o After this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.
neral Director: # 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 M.D. March 31,2009 D0065505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qiufang Cheng, M.D. 9901 Medical Center Dr, Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) 07 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:35a M Virginia C. Kane April 5, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care of Potomac Potamac If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs 81 Director 577-40-0822 November 24, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at MD Montgomery Olney 1 Yes 20 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4317 Mt. Olney Lane 20832 USA death Funeral teme 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes **XX**No Specify. White þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Administrative Assistant 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Frances Buonviri Carmelo Collova 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Eileen R. Pearce 4317 Mt. Olney Lane, Olney, MD 20832 / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of t
Important: If ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 8, 2009 Silver Spring, MD Gate of Heaven Cemetery 4 □Donation 5 ☑ Other (Specify) Entembrent 21. Signature of Funeral Service Lice 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanted Demen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760, by Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 0 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d, Date signed (Month, Dev. Year) 29b. Signature and title of certifier 2 00054566 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arma HI-17 Silverspring MDZ902 Sunitha Bhogavilli 9 sol Creongia 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar 07

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		For State	ate of Maryla	and / I	•	rtment of F <i>rtificate of t</i>			giene Reg. No.	2000	12767
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/Medic Examin		4a. Facility Name (If not institution, give street				4b. City, Town, or	Location of Dea		4c.	County of Deat	h
<i>-</i>		Southern Maryland Ho				Clinton				rince G	
Funeral		5. Social Security Number 6. Sex	7. Age (In y		irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	y, Year)	Co	thplace (State or Foreign buntry)
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	M01555)		. Name and Addre		ee Funer			
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		shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.	i Do	- Hot chi	/ li	ig, scorr ao oaran	io or respiratory as	1000,		Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d				y 101					
h cert	In/M	23b. was decedent pregnant	yes, outcome of pre ☐ Live birth 2☐ F	gnancy	h al	∃Ectopic pregnanc				23d. Date of de	
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spita nours neral y fillec		29a. Certifier 1 Certifying Physicia	n: To the best of my	knowledg	ge, deat	h occurred at the ti	me, date and pla	ce, and due to the	cause(s) and manner a	s stated.
he Ho in 24 I he Fu pletel	Medical	(Check only 2 Medical Examiner: one)	On the basis of examand manner stated.	nination a	and/or in	vestigation, in my	opinion, death occ	curred at the time,	date an	d place, and du	e to the cause(s)
To the vith To the come	Σ	29b. Signature and title of certifier				29c. Licens				te signed (Mon	th, Day, Year)
		1 /15 T. 16				32 1	9889	į (04/-	03-	2009
RIGH		30. Name and address of person who comple	eted cause of death (Item 23a	(Type,		ERM	A		D	20027
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	8		CNN	706 24		1) ((00)(
Registr		APR 0 7 2009	Peneva	1.	1	hare					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#5perFH4/13/09,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 1 Day 09 Year Month 03 **Physician** Newton Littleford Sr 18:22pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner George Prince Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 11/9/61 5. Social Security Number 9906 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours **1** M 2 □ F Washington, DC 47 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, it a modified at Yes 2 No Director Md Prince George Temple Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4505 Akron Street 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black ੬ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unemployed 12th 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawerence A. Littleford Mary Ann Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 9539 Muirkink Rd Laurel, Md 20708 Department of Health Important: If item 27 any injury or other trong. Lawernce Littleford Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Riverdale Crematory 04/08/09 Riverdale, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 25MeadAdMorfedary Service, P.A. 1409 Fairlakes P SteB Mitchellville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Inthother, Physician viarhal disease or condition resulting in death) /Medical Due to (or as a conse in nce of): Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami sician and burial-trans Due to (or as a consequence of) physician s the burial Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 T Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Strentococcus Viridany fight aunin 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed Enol Hu Kinul Discon 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 1 □ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. n 24 hours after death.

• Funeral Director; A

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State

DHMH 17 Rev 1/2001

Medical

29a. Certifier

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Kilhard

31. Date filed (Month, Day, Year)

(Check only

29b. Signature and Atla

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328

2. Registrar's Signature

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1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00055120

Southern avenue SE Sich 310 Wahragton De

29d. Date signed (Month, Day, Year)

			For State Registrar			rtificate of		Reg	g. No.2	12769
	Physici		1. Decedent's Name (First, Middle, La: Kate Maria	Lohmann				2. Date of Death Month March 3	31, 2009	3: Time of Death 4:50 P M
No.	/Medio		4a. Facility Name (If not institution, giv				r Location of Death		4c. County of Deat	
	Funeral		201 Diamond Dr 5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign untry)
	Director		128-30-7618 Usual Residence of Decedent	□M 2\\ F 90	Yrs.			April 2	3,1918 Ge	rmany
	faryland f show	or	10a. State 10b. County		City, Town or Lo $alkers$					10d. Inside City Limits 1 √ Yes 2 No
	or 28a-	Funeral Director	Maryland Freder: 10e. Street and Number		arkers	10f. Zip Code		109	g. Citizen of What Co	untry?
	eath wi	eral	201 Diamond Dr	12. Was Decedent Ever in	UIS 13	2179		pecify Yes or No-	14, Race - Ame	rican Indian.
036	urs after de al'', or item Examinera	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2/1/2/No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.
1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Modical Examinar must be retified at once.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired retary	pation during most of work d)	king	6b. Kind of Business/ $ m Brewerv$	Industry
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Maryland	hould b id Ment marked matic e	2	Otto Peus, Sr.	Type Print)	19h Maili	na Address (Street	Antonie		City or Town, State, 2	Zip Code)
	and 2 s ealth ar n 27 is ner trau		Trudy K. Murtau	gh / Daughte	er 201	Diamond	l Dr., W	alkersv	ille, MD	21793
Baltimore,	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Opecing)	Removal from State	b. Place of Dispo cemetery, crea Rest Memori	position (Name of matory or other place haven al Gard	ens Apri	11 7.	oc. Location - City or Tredericl	Town, State k, Maryland
Balt	permit. Depart Import any inj		21. Signature 15 neral Service Cer	nsee	Ř 9	estnave 501 Cato	n Funera ctin Mt	al Servi n. Hwy.	ces, Skko Frederic	ot Cody P.A. k, MD 21701
	Physician		23a. Part 1 Enter the disease, or comshock or heart failure. Let only Immediate Cause (Final disease or condition resulting in death)	a Cerel	ind	ter the mode of dyli	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
٦	/Medical Examiner			Dw to (on as a cons	sequence of):	tie Va	rculo	Assen	1	Wys
	nsit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t (or as a cons	sequence of):					30 yrs
68760,	tificate be executed ig physician and as the burial-transit	cal Exa	that initiated events resulting in death) Last	Due t (s cons	sequence of):					0
O. Box	Attending PhysIcian: The law requires that the death certificate releath. ector: After this certificate has been signed by the attending physis by the funeral director, page 2 should be detached for use as the the tuneral director.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnand	су		23d. Date of del Month	livery Day Year
rds, P.	w requires that s been signed b should be deta	ed by Pt	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	o the cause of death? robably 4 □ Unknown
Division of Vital Records,	Physician: The law re this certificate has ber al director, page 2 sho	Completed						24a. Was an autopsy perform 1 □ Yes 2	24b. Were at prior to death?	utopsy findings available completion of cause of
Vita	slcian: certifii irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	D EB/Outpatio	nt all DOA Oth	or:	th (Check only on		and d
on of	ding Phys th. After this funeral di	tion: Tc	27. Manner of D ath 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day, Yea		of 28c. Inju	4 LI Nursing n	28d. Describe hov	nce 6 □ Other <i>(Spe</i> v injury occurred	ыу)
Divisi	Dir Oir	Certification: To	3 Suicide 6 Could not b		t home, farm, st ecify)			28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	the Hospital or thin 24 hours afte the Funeral Dir mpletely filled in	Medical C	29a. Certifier (Check only one) Certifying Plant Certifying Plant Medical Example Medical Example Certifying Plant Medical Example Medical Medical Example Medical Example Medical Example Medi	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	th occurred at the to	ime, date and place opinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
	the ithin o the	Me	29b. Signature and tille of certifier	1	Λ .	29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)

Year se contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No ☐Other (Specify) occurred d Number or Rural Route Number, and manner as stated. e signed (Month, Day, Year) 09

State Registrar

DHMH 17 Rev 1/2001

Alan Carroll, 31. Date filed (Month, Day, Year) APR U 6 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

310 S. Seton Ave., Emmitsburg, MD 21727

			1- For State of Maryland / Department	artment of Healt		al Hygiene	000 12770
	Physicia	an	1. Decedent's Name (First, Midgle, Last) ARIONR. UCAS			ate of Death onth Day	Jung 3. Time of Death 750 PM
	/Medic Examin		4a. Fecility Name (It not institution, give street and number) Word vole Nunsing Centr	4b. City, Town, or Locati	tion of Death	40.	Jounty of Death MUNTSULYERY
	Funeral Director		5. Social Security Number 579–38–7626 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. (8. Da urs Min. (M	ate of Birth forth, Day, Year	9. Birthplace (State or Foreign Country) Virginia
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Minportent: If laten 27 is marked other then "natural", or terms 23e or 28a-f ehow any injury or other traumatic event, the Medical Examination must be notified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
		ctor	2.0	ington			1 Yes 2 □ No
	with the	Dire	10e. Street and Number 4644 Hunt Pl., N.E.	10f. Zip Code	019	10g. Citiz	zen of What Country? U.S.A.
	death	Funeral Director		Was Decedent of Hispanic If Yes, specify Cuban, Mex		es or No-	14. Race - American Indian.
9800	ours after rai', or It	d by Fu	1 Never Married 2 Married 1 Yes 2 No	1 Yes 2 No Spec			Black, White fican— Affican— Specify: American
215-(ıin 72 h ın "natu Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during r DO NOT use retired)	most of working	16b. Kir	nd of Business/Industry
21	e filed within al Hygiene. I other then " vent, the Me.	Com	12th Car	rd Puncher	Anthodo Novo (Circ		.Census Bureau
land	should be fi and Mental H s markad ott umatic ever	To Be	17. Father's Name (First, Middle, Last) Malachi Rowe	18. M	Marion	_	Sumame)
Maryland 21215-0036	ind 2 shoualth and Maith and Missing in 27 is mail or traumal		19a. Informant's Name/Relationship (Type, Print) James S. Lucas, Jr./Son 19b. Mailin 464	ng Address (Street and Nu 4 Hunt Pl., N	umber or Rural Rout I.E.,Washi	te Number, City or .ngton,D.	Town, State, Zip Code) C. 20019
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.			osition (Name of matory or other place) Mem. Cem.	04/09/0		cation - City or Town, State tland, Maryland
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee 22. Aug N. Aug 4.	^{2. Name and Address of Fi 925 Burrough}	ngton & S s Ave.,N.	Sons Co., E.,Washi	Inc. ngton,D.C.20019
			23a. Part 1. Enler the disease, or complications that caused the death. Do not ent shock, or hear failure. List only one cause on each line.	ter the mode of dying, such	h as cardiac or resp	iratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Severe demen Due to (or as a consequence of):	ha			
l	Examiner						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events				
8760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
687	.0 0 0	edicai	d				
O. Box	death cer e attendir od for use	Physician/Med		□Ectopic pregnancy □ Other (specify)		2	3d. Date of delivery Month Day Year
s, P.O	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contribuling to death but not resulting in the u		Part I. 2	3e. Did tobacco u	se contribute to the cause of death?
ord	w require been sig should b	eted !	Angurpan. Spinal Stenoso	ease Abdon	mico	1 Yes 2	
Vital Records,	The ate h page	Completed	aneurom. Spinal Stenosis	,		4a. Was an autopsy performed? ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	Physician: The this certificate he ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier		Place of Death (Che Nursing Home 5		COther (Specify)
on of	Attending Physrdeath. cdeath. ector: After this by the funeral di	$\vdash $	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury		28d. D	Describe how injury	
Division	al or Atter s after des l Director d in by the	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sin building, etc. (Specify)	reet, factory, office		ocation (Street and ity or Town, State)	d Number or Rural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date vestigation, in my opinion,	te and place, and du , death occurred at t	ue to the cause(s) the time, date and	and manner as stated. place, and due to the cause(s)
ı	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License numb			e signed (Month, Day, Year)
- 1	7		30. Name and address of person who completed cause of death (Item 23a) (Type,		30/	4/	2/04
	/			,	ver Sprin	ng,Maryla	ind 20910
	Sta Registr	-	31. Date filed (Month Day Year) 2009 22. Registrar's Signature	Mad			

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 State Registrar AMEND#23boerMD, 4/7/09, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vivian Marie Morris 3Ó, 2009 1:05 a M March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Rehabilitation Center Burtonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🛛 F Washington, DC Director 577-14-3655 88 July 28, 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 3 death with 3152 Gracefield Road MS 213 20904 United States Funeral or Items ; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Item edical Examiner r Black, White, etc. d 2 should be filed within 72 hours after of th and Mental Hygiene.
7 is marked other than "natural", or Itel traumatic event, the Medical Examiner 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: 3 ☑ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miles Sv1vester Gould Virginia Robertson 2 Ann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other 10310 Crestwood Drive; Charlotte, NC 28277 Gregory Morris / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lincoln Crematory 4/07/2009 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate C.u. (Final disease or condition resulting in death) **Physician** Advance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Dav Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.0. signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After I Division or Attending 5 ☐ Pending investigation 1 Alatural To the Hospital or Autoria, within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Suni Ina Bhogavilli Silverspring MD 20902 FI-1 # WKW H Registrar's Signature 31. Date filed (Month, Day, Year) State APR 06 2009 Registrar

			State of Maryland / Department	nt of Health and Mental H	lygiene 2000 1277
			1. Decedent's Name (First, Middle, Last)	2. Date of	neg. ne:
	Physici		William Clayton Marques	Month	Day Year
way.	/Medi Examir			Town, or Expection of Death	4c. County of Death
	xaiiiii		Suburban Hospital B		Montsomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	r 1 Year If Under 24 Hrs. 8, Date of I	Birth 9. Birthplace (State or Forbign
	Director		5/8-02-3/84	Days Hours Min. (Month, May 21	
	land bw		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location		
		5			10d. Inside City Limits 17∑ Yes 2 ☐ No
7	the N	ect	MD Montgomery Silver Spring 10e. Street and Number 10f. Zi	0.1	
	with	ä		p Code 906	10g. Citizen of What Country?
	72 hours after death with the Mary natural", or items 23a or 28a-f sh iten Examinat must be motified	Funeral Director			USA No- 14. Race - American Indian,
(0	fter d riten	표	Armed Forces? 1 \(\mathbb{X}\) Never Married 2 \(\mathbb{M}\) Married 1 \(\mathbb{Y}\) Yes 2 \(\mathbb{X}\) No	dent of Hispanic Origin? (Specify Yes or lecify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
03(urs aft al", or Eventi	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes	2 ▼ No Specify:	Specify: White
21215-0036	72 hours "natural",	Completed by	15. Decedent's Education 16a. Decedent's Usu (Specify only highest grade completed) (Give kind of wo	al Occupation	16b. Kind of Business/Industry
2	within lene. than "	du	Elementary/Secondary (0-12) College (1-4or 5+)	ork done during most of working se retired)	
	ed wi		12 Truck Dri		Tow truck
ng	be fill htal H hd oth even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
yla	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Italia	2	Peter Marques		orvat
Maryland	12 sh hand 7 is n Fraun	l, h		S (Street and Number or Rural Route Num	
	1 and Healt em 2 ther	3	Dona L. Dwyer mother 4304 Garre 20a. Method of Disposition 20b. Place of Disposition (Na.	ett Park Rd, Silver	
nor	ages int of t: If it		1XXBurial 2 Cremation 3 Removal from State Park lature Mem	other place) 4/6/2009	20c. Location - City or Town, State Rockville, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, It a featler once.		4 Donation 5 Other (Specify)		
Ba	permi Depar Impor any Ir		Danzar	nd Address of Facility nsky-Goldberg Memor	ial Chapels, Inc
		-	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the modern	MOCKVIIIE FIRE, ROC	KVIIIe, MD 20852
			shock, or heart failure. List only one cause on each line.	le of dying, such as cardiac of respiratory	Interval Between Onset and Death
	hysicían /Medical		disease or condition resulting in death) a. Due to Jorks a c / sequence of:	7	Dank
	Examiner		Han along		
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a vonsequence of): c. Due to (or as a consequence of):		
5	cured nd ransit	Examiner	Cause (Disease or injury that initiated events		
oʻ	e exe ian al ırial-t		resulting in death) Last Due to (or as a consequence of):		
vision of Vital Records, P.O. Box 68760,	iicate be executed physician and s the buriat-transit	lical	d		
39	ing p	Physician/Med	IF FEMALE:		
Вох	attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	pregnancy	23d. Date of delivery
0	the a	sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (st. 9 ☐ Unknown		Month Day Year
٩.	d by letach	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying c		
Records,	arres that the de signed by the a d be detached f	Completed by			tobacco use contribute to the cause of death?
Ö	been s	etec	Degretsion		Yes 2 No 3 Probably 4 Unknown
3ec	cate has page 2 s	du		24a. Wa	opsy prior to completion of cause of
a	certificate ector, pag			per 1 □Yes	formed? death? 2. No 1 □ Yes 2 □ No
Vital	certifi rector,	m	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check only	
of	r this ral di	۲.	1 Inpatient 2 EH/Outpatient 3 DC		sidence 6 ☐ Other (Specify)
on	h. After funera	틶	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) Injury	Mark2	e how injury occurred
Division	deat ctor: y the	lica	2 M Suisido 6 Could not be		
	s after death. I Director: A id in by the fu	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)		(Street and Number or Rural Route Number own, State) 4304 Gold eff Pork
io Latingon	within 24 hours after To the Funeral Directory Completely filled in L		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and due to the	ver Spring, mp
1	n 24 ł ne Fu,	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation and manger stated.	, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
Ę.	within To th	¥	29b. Signature and title of certifier 29c	. License number	29d. Date signed (Month, Day, Year)
1	5		Man BACKEN MODINE !	000428	APY 3 2009
				Ira N. Brecher, M.I	1.11.
			2101 Medical Park Dr. #304, Silver Spring,	MD 20902	
	Stat	~	31. Date filed (Month, Day, Year) 32 Registrar's Signature		
	Registra	ır	APR 06 2009 Cedur A. Jan.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** 2009 2340 RIIRY LEE MITCHELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Holy Cross Hospital MONTGOMERY Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs 93 153-28-1160 Mar. 22, 1916 Georgia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Show 1 □Yes 2X No Silver Spring d other than "natural", or items 23a or 28a-f shevent, the Wedical Examination and the Director Montgomery MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or any injury or other traumatic event 20904 U.S.A. 13120 Riviera Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ∐Yes 2√ No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Black If Yes, Give Š 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Food Service Dietician 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David L. Williams Ida P. Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 9 0 4 19a. Informant's Name/Relationship (Type. Print) 13120 Riviera Terrace, Silver Spring, MD James A. Mitchell (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from hklin Mem Park 4/8/09 New Brunswick, NJ 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 231. Part 1. Enter the disea 1, or complications that caused the deap shock, or heart failure. List only the cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Advanced Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 ☑ No P.O. the 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No 2√ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Ashish Tolia, M.D.

3. Registrar's Signature 31. Date filed (Month, Day, Year) 2009

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

H0064588

1500 Forest Glen Rod, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rosemary Ann McQuade 1:01p M 2009 April 3, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring <u>2812 Munson Street</u> If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 🔀 F 577-34-0874 79 November 17, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Silver Spring 1 Yes XX No Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 USA 2812 Munson St. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ∐Yes 2**XX**No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐Yes 2 🗓 No Specify. White þ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Army Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical Center 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barbara Varqo ဂ Andrew Yurko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted McQuade / Son 2812 Munson St., Silver Spring, MD 20902 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Metropolitan Crematory April 4, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fure of Funeral Service Licency e 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Daley chardI 500 University Blvd. West, Silver Spring, MD 20901 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ∐Yes 2 🔀 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

burial-tran physician at the burial attending ph cate has been signed by the page 2 should be detached certificate ours after death. eral Director: After this certific filled in by the funeral director, I

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, the Medical Evorating Tright to preference and any in-

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

4 Homicide 29a. Certifier

29b. Signature and the

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 3, 2009

1 X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and of person who completed cause of death (Item 23a) (Type, Print)

Jeanne P. Asher, M.D. 3720 Farragut Ave., Kensington, MD 20895

and manner stated

31. Date Month, Day, Year) State 07 Registrar

Registrar's Signature

within 24 hours a To the Funeral I

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completely

Medical

29c. License number

D34032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Vivian Lucille Mowbray /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/30/1922 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 X F 86 213-16-1543 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be refilled at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Washington Hagerstown MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 US 1333 Marshall Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White Completed by 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth (unk) Eichelberger Wilbur Amos Nokes ပ္ 19a. Informant's Name/Relationship (Type. Print)
Terry L. Mowbray / Son Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 11 N. Cleveland Avenue, Hagerstown, MD 21740 Terry L. Mowbray / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 04/11/2009 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending | for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 □ Yes 2 ∰No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the rector, page 2 standard autopsy perform 2 No 1 🗆 Yes this certifical director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation d in by the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April Day **Physician** MADELYN M. MITCHELL 2009 4:45 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BERLIN NURSING & REHABILITATION WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1-12-1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 👿 F DELAWARE 222-09-3130 Director 87 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director SUSSEX FRANKFORD DELAWARE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and 2 should be filed within 72 hours after death with 19945 IIS 34857 PEPPER ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Ki No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married tchell, Madelyn altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE <u>م</u> Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER NONE 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALTER LOWE CARRIE MITCHELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DON MITCHELL/ SON 30350 MUMFORD ROAD, MILLSBORO, DELAWARE. 19966 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trong. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State MIJLLSBORO CEMETERY 4-8-2009 MILLSBORO, DELAWARE 21. Sign ture of Funeral Sen 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseashock, or heart failuge e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** 4THEROSCLEROIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
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1 □ Yes 2 ☑ No 24a. Was an certificate has be irector, page 2 sl autopsy perform 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 7 6/4

Registrar

State

31. Date filed (Month, Day, Year)

APR 08

32. Registrar's Signature

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	Funeral Director		5. Social Security Number 6. Sex 191–34–9639	7. A	Age <i>(In yrs. la</i> 91	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Sept 1	rth ay, Year I , 1	9. Birti 917 Penn	nplace (State or For untry) sylvania	eign
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Baltimore,	Depart Import any in	:	21. Signature of Funeral Service License	Della	MO		_						P.O. Bo arksvill	x 784 e, MD 210	29
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Division	or Att fter d irect n by	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir building, e	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory,	office		2	28f. Location City or To	Street a wn, Sta	and Number or Ru ite)	ral Route Number,	
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	ithin ormple	Mec	29b. Signature and title of certifier	and manners	Juliou.		29c.	. License	number			29d. D	ate signed (Monti	n, Day, Year)	
	FSFö		71 /WW					32036					ril 6, 20		
	2		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type							•		
(8	B) ar		Gary Sprouse, M.D.					neste	er. M	1D 21	519				
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 8 20	32. Regis	trar's Signatu	ire									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02546 State of Maryland / Department of Health and Mental Hygiene Jimmie McNair Certificate of Death 1. For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ March 31, 2009 0920 hrs Jimmie Jenopulous McNair Medical Examiner Jimmie McNair 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 6872 Hawthorne Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Country) Min. Days Hours Director North Carolina 579-58-9804 Yrs 1947 1 xM 2 62 Usual Residence of Decedent 10d. Inside City Limits 10c City, Town or Location 10b. County any 10a. State 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. MD Prince George's Landover permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20785 6872 Hawthorne Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 1 Yes 2XX No specify: Specify: Black f Yes, Give Year 3 Widowed 4 X Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Government Mail Clerk 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Odessa Mace Be Neil McNair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 6872 Hawthorne St, Landover, MD 20785 Regina McNair/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4/15/2009 MD Veterans Cemetery Cheltenham, MD Donation 5 Other Specify. 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of F eral Service Licensee 7474 Landover Road, Landover, MD 20785 23a. Part I. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit 1 per me g900 Physician/Medical 2-22-10 vt X AMENDED UNPENDED attending physician or use as the bunal To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death signed by the attending be detached for use as 1 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. No 3 V Probably 4 Unknown Yes 2 ģ Chronic alcohol abuse Completed 24b. Were autopsy findings available 24a. Was an page 2 should has been prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 1 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Residence 6 V Other: Scene examiner? Nursing Home 5 Inpatient 2 FR/Outpatient 3 this 1 Yes ို No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 🗸 Natural Yes 2 No Pending within 24 hours after death. To the Funeral Director: I Director: ed in by the I Investigation 2 Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide determined filled Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 1, 2009 O.C.M.E. and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD

State Registrar

31. Date filed (Mor

78 2009

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 Day 2009 4 5:56 a^M Arleen Scuka Morgan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Year 9-30-1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Year) Months Days Hours Min 1 ☐ M 2 🖾 F 577-88-9108 52 Utica, NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Prince Georges College Park tX□Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 United States 4802 Iroquois Dtreet 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2t No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nella Tregnaghi Dario Scuka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Morgan/Husband 4802 Iroquois Street College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 kg Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4-10-2009 Brentwood MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses <u>3401 Bladensburg Rd Brentwood MD 20722</u> 23a. Part 1. Enter the disease, or complications that oused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIC NCE PHALOPATHY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a nonsecuence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BRUGADA'S SYNDROME 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of END STAGE RENAL DISEASE autopsy performed? Ves 2-No 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

72 hours after

s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth

permit. Pages 1 a.
Department of Hea
Important: If item 2
any injury or "."

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a I be detached f certificate has birector, page 2 st After this certific funeral director,

Records, Division of Vital or Attending nours after death.
neral Director: Af 24 hours a Hospital within 2 To the

Box 68760,

P.O.

15 State

Completed by Be Certification: To 27. Manner Death Medical 29a. Certifier

1. atural

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined



M.D

Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

TAKONA PARK,

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Registrar

completely

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 5.50A M Sarah Mae Miles 7009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Doctor's Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. 1-26-1922 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year Hours Months Days Min. 578-28-0332 Prosperity,SC Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: filems 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinat nast by notified at once. 1 Tr Yes 2 □ No Director MD Prince Geroges Seat Pleasant 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 United States 6904 Seat Pleasant Drive Apt 101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 ∐Yes 2 ဩ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No Baltimore, Maryland 21215-0036 1 ∐Yes 2 🔀 No Specify: Black ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Recreation Specialist DC Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Harmon Sarah Thompson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 614 71st Ave Seat Pleasant MD 20743 Montzine Bowles / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4-13-2009 Brentwood MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): 1 week Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed ours after death.
neral Director: #

24 hours a Funeral L within 2 the ٥

29b. Signature and title of certifier Johned Jeunit 29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

00058213

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARHAD JAMAN MD 7575 Original Ctr Dr. Original MD 70770

State Registrar

Medical

4 Homicide

(Check only one)

29a, Certifier

		1 - State of Maryland / Department of Health and Certificate of Death		ijene _{eg. No.} 2009 2782
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) PASCALINE T. MOMULOUH 4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL 4b. City, Town, or Location of Deat TAKOMA PARK	2. Date of Deat Month MARCH	th Day Year 3. Time of Death 3.1 2009 11:56 P M 4c. County of Death MONTGOMERY
Funeral Director		WASHINGTON ADVENTIST HOSPITAL 5. Social Security Number 5. 9-47-0080 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. TAKOMA PARK 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9 Birthplace (State or Foreign
Baltimore , Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Extrining Institute and once.	To Be Completed by Funeral Director	WILLIAM MOMULOUH 19a. Informant's Name/Relationship (Type. Print) BLANDINE N. MOMULOUH/SISTER 19b. Mailing Address (Street and Number or R. 15019 DISDALE DRIVE S. 15019 DISDALE DRIV	specify Yes or Noto Rican, etc.) rking me (First, Middle, Machine, Machine) ILVER SP Date / 2009	
by / bu, by sician and Examiner physician and the burial-transit	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	c or respiratory arr RE MONI	Onset and Death
BOX C Bath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
Accords, F.O. e law requires that the de has been signed by the le 2 should be detached	Completed by F	Part In Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. REIVING R	23e. Did tol	n 24b. Were autopsy findings available
UNISION OF VILSI RECORDS, To the Hospital or Attending Physician: The law requires twithin 24 hours after death. On the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Be	examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	ath (Check only on Home 5 ☐ Reside	2 □ No 1 □ Yes 22 □ No
DIVISIO DIVISION Hospital or Attendi 24 hours after death Funeral Director: /	Certification: To	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	
To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 29b. Signature and title of certifier 29c. License number	urred at the time, d	
Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PIOTR N. WYRWINSK! 7600 CARROLL AVENUE 31. Date filed APR 08 2009 32. Registrar's Signature	E TAKOMA	PARK, MARYLAND 20912

Please Type or Print in Black Indelible Ink 5 Fn sure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12009 OROTHY /Medical Examiner FORTWaskington MA FORT WASHINGTON HEA ITH + Rehab 7. Age (In yrs. last birthday) Yrs. If Under **Funeral** Months Days Hours 230 14 7504 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location I show or other traumatic avant, the Madical Examiner must be notified at PRINGE GRONGE'S 1 ☐ Yes 2 No FORT WASHING-TON Funeral Director or 28a-f 10e. Street and Number 10g. Citizen of What Country? 20744 USA DRIVE "natural", or Itams 23a NO OM death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tited within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "in any Injury or other traumatic svent, the Medianone. Elementary/Secondary (0-12)
HAN School College (1-4or 5+) HOUSE WIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, Carlot Town, State, Zip Code), 7 46 Schafer M. S. 19a. Informant Name/Relationship (Type, Print) 20c. Location - City or Town Ctate
Russian 11/05 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Northern Neck Crematory 3/17/09 Burgess, VA Bast-Stauffer Funeral Boonsboro, MD 21713 Littome Heathsville 21. Signature of Funeral Service Licensee Paul, Dean per DVR2. Name and Address of Facility Jones-Ash tuneral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATheroscleratic Cardin Varila **Physician** 55 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: **N/A**3 □ Ectopic pregnancy 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown the 9□ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably # Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificete 1 ☐ Yes 2 ☐ No 1 Yes 20 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1-Natural 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funeral I To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NKS365 03-16-6009 M. 1; ringston R/ H/of flwashington and 20785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 idaneas

State

Registrar

31. Date filed (Month, Day, Year)

APR 15 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:51P™ 2009 MARCH 28, NANCY PAGE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY BARNSIDE PLACE ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🕅 F March 23, 1956 Iowa Director 216-64-0884 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States of America 506 Barnside Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 【 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify Caucasian Completed by 3 Widowed 4 Divorced "natural" if Health and Mental Hygiene.
item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Human Resources Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeanne Jackson Landy Altman ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 nent of Health a. nt. If item 27 is. Vladimir Nacev - Husband 506 Barnside Place, Rockville MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department of
Important: If i
any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 04/07/09 Brentwood, Maryland 21. Signature of Funeral Service 22. Name and Address of FacilitySimple Tribute Funeral & Cremation 1040 Rockville Pike; Rockville MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of) **Examiner** 2 years Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as 1 attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 ☑ No page certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending Injury 1 🔀 Natural 5 Pending ywithin 24 hours after death.

To the Funeral Director: After Afte 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jason Duelge March 30, 2009 42634-020

Registrar

366 Rutgers Street, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jason Duelge, M.D.,

07

31. Date filed (Month, Day, Year)

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 April 4, Physician Martha Fields Nichols 20:10 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Hospital Prince Georges Ft. Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 1 F 229-26-5918 83 Director April 30,1925 Franklin, Va. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince Georges Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5711 Ottawa Street 20745 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Maid Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lonnie Ricks Martha Fields 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 department of Health at Important: If item 27 is any injury or other trau Ottawa Street Oxon Hill, Md. 20745 Paula D. Ware / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4/11/09 Southview Cemetery Franklin, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S: Pope / Profestville, Md. Pull Davis M01085 20747 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ADVANCED DEMONTIA **Physician** LNKNOWN /Medical Due to (or as a consequence of): Examiner ASPIRA tur UN KNOWNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dup to (or as a consequence of) Examiner FOR KINSON'S The law requires that the death certificate be executed he KNO WH and burial-trar Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O, Box 68760, (TATUS Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20744-5164 11711 Livingston Rd. Ft. Washington, Md. Kleiman, M.D. Samuel State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2009 April 3, **Physician** Todd Emmanuel 2:56 P M Pagan /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 22, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 M 2 □ F 237-02-9162 North Carolina 1959 **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Exacting at must be notified at Director 1 Des 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600-C East Gude Drive 20850 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, I'm Modical Ext. of activities Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Samuel Pagan Dorothy Louise Benson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashiele Monicque Smith/daughter 4196-E Gardner Ridge Drive Gastonia, NC 28056 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or oti
once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 04/07/09 Odenton, MD 21. Signature Funeral Galary and the Cremation Service P.O. Box 784 MO125 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a.Cardiac Pulmonary Arrest /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Brain Death Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a detached if 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Das

State Registrar Qiufang Cheng,

31. Date filed (Mont)

9901 Medical Center Dr. Rockville, MD 20850

MD

32. Registrar's Signature

Enerce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D0065505

Abril 3,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** аМ 4/1/2009 EPHESIANA BERNARD PIXLEY 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE"S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 1 M 2 □ F Months Days Hours Min. Director 70 240-54-5142 1/1/1939 Johston, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminat must be notified at any injury or other traumatic event, Ita "Maryland Exeminatic ev 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYes 2 □ No Prince George's Maryland | District Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 2701 Overdale Place 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2**K** No Specify: Black 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Private Butcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George Pixley Lucille Medlock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Overdale Place District Heights, MD 20747 Wife Lessie Williams Pixley / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/8/2009 Waldorf, Maryland Heritage Memorial 21. Signat of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardioney ogn Tay Dilated **Physician** Unknow disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of and burial-trar Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform After this certificate 2 No 1 ☐ Yes 2 XNo 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier completely (Check only one)

Division of Vital Records, Physician: Hospital or Attending

death.

the

5

law requires that the death certificate be executed

P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the within 7

> State Registrar

29b. Signature and title of certifier

Rates Fach

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Are suit 3-32 Silver Spring MD20902 9801 ROINTAN FARAHIFAR

M.D.

31. Date filed (Month, Day, 2. Registrar's Signature 29c. License number

D43446

29d. Date signed (Month, Day, Year)

4.1.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ouintanilla Manuel Dolores 28,2009 8:10p M March /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Rockville Casey House If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 214-11-3423 6. Sex **Funeral** Months Days Hours Min. El Salvador 1 X M 2 □ F 77 Director 3/18/1932 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Medical Event in the benefited at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Montgomery Village 1≹Yes 2□No Director Md Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20886 El Salvador 9800 Walker House Road #3 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ıXıyes 2□No El Salvadoren White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Dishwasher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalia Ouintanilla Tomas Hernandez ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 20043 Mattingly Terrace Gaithersburg, md Jose Abraham Serpas/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 D Cremation 3 Remayal from State Gate of Heaven 4/03/2009 Silver Spring, Md 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature Funeral Service Licens PHYTETP MESKIMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastric Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Il or Attending Physician: The law requires that the death certificate be executed safter death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Division of Vital Records, Completed by y 4 【XUnknown

Be

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
	1 ☐ Yes 2 ☐] No 3 ☐ Probably 4 🔀 Unknown
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	1 ☐Yes 2 No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing H	Home 5□ Residence 6峇Other (Specify) hospic						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		28b. Time of lnjury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, factory, cify)	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						

29a. Certifier				urred at the time, date and place, and due to the						
(Check only one)	y 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and	title of certifier	6 0		29c. License number	29d. Date signed (Month, Day, Year)					

29c. License number 20063748 29d. Date signed (Month, Day, Year) March 30,2009

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1 ocelyn (30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road Rockville, Md. Koudtchou, MD Jocelyne

State Registrar

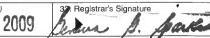
Medical Certification: To

filled in by

completely

To the Hospital o within 24 hours af To the Funeral D

31. Date filed (Month, Day, Year) APR 08



Kouerchou, ms

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** David Rothenberg April 2009 1:55 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home Of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 X M 2 □ F Director 78 3, 1930 New Hampshire Sept. 002-20-8526 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It was leaf Exprining the result for items. 1X Yes 2 □ No Director Silver Spring MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 15107 Interlachen DR. #322 20906 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Postal Service Letter Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ပ Jacob Rothenberg Dora Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15107 Interlachen DR. #322 Silver Spring MD 20906 Judith Rothenberg/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/3/2009 Olney Maryland Judean Mem. Gdns. 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licens 1091 Rockville Pike, Rockville MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Uniciown is certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2210 1 □ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

6514

31. Date filed (Month, Day, Year)

IROSE

6121 MON

29d. Date signed (Month, Day, Year)

and manner stated

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2 Date of Death POSEN FEL Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖵 F 86 579-14-4335 Director June 2 1922 Wash. DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Medical Examiner must be notified at **Funeral Director** MD 1 √Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 6121 Montrose Road 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 10, Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 朝 12 Program Analyst 27 Is marked other er traumatic event, the Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Buchalter ဥ Nettie Kite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other tr once. <u> Ann Nimetz - Daughter</u> 14828 Soft Wind Dr. North Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Judean Mem. Gdns 4/5/09 Olney, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has l 1□ Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28h Time of After 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 🗌 Yes within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) To the 29b. Signature And title of certifier 29c. License number
D 35436 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) Registrar

INTROSERD, ROCKVILLE, MD 2089

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Please Type or Print in Black Indelible lok. Encypo All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 5,2009 Year **Physician** 0012 Romanova Olga /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 / 0 4 / 1 9 4 5 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 64 219-45-7029 Russia **Director** Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h. County 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination ust be notified at Rockville Montgomery MD 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Russia 20852 10401 Grosvenor Place #704 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ∐Yes 2 Mar If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Inter.Monetary Func Interpreter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Galina Smirnova Victor Romanov ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traumonce. 10401 Grosvenor Pl.#704 Rockville,Md.20852 Roman Romanov/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 4/07/2009 Beltsville, Md. 5 ☐ Other (Specity) 4 Donation PHTT and Address of TOTALDI FUNERAL SERVICE, P.A. of Funeral Service Li 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ATHERO SCLEROSI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DNCREATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit NECMONI Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐ Yes 2 No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗔 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner areath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) · 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Records, P.O. Box 68760,

@ 8013 FE

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ROMANOVA,

altimore, Maryland 21215-0036

signed by the a cate has been si Division of Vital To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

. Signature and title of certifier	29c. License number	29d. Date signed 44/05/2009
Willian Swan 00	H37188-04	65/09
	d Georgetown Rd Be	thesda,Md 20814

State Registrar 31. Date filed (Month, Day, Year)

(Check only one)

29b

and manner stated.

Amended Item 5 per F.D. 04/08/2009 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April Ő1 2009 5:15 p M Donna Jean Rodgers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Ye Jan 11 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex .247LS40W21879 **Funeral** ^{Year)} 1944 1 □ M 2 🔀 F Months MD 217-40-2773 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h. County show ral", or items 23a or 28a-f shore Experient must be notified at 1 ☐ Yes 2 ☑ No Director Finksburg MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21048 1702 Fawn Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐XIo Specify: Specify: ò White 3 ₩ Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick F. McKay Mary Teresa Franco မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 4609 Wentz Road Manchester, MD Jeff Rodgers/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04/0692009 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signature of Funeral Service Licensee Printer TuneralivHome and Chapel, P.A. Westminster, MD 21157 412 Washington Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 3611799 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🔲 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ∐Yes 2 ☑No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice Certification: To After this 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

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Hospital or Attending

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

The law requires that the death certificate be

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Mo

Kus

and manner stated.

tone

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien [] []

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		•	For State Registrar	State of Mic	,		rtificate of				Reg. N		1 100 1 0
	Physicia	n	1, Decedent's Name (First, Middle,						2	2. Date of De Month April	ath D	ay Year	3. Time of Death
	/Medic	al	Donna Jean Rus				4b. City, Town, o	- Location of		April	_	c. County of Death	2:14 A ^M
	Examin	er	4a. Facility Name (If not institution, Casey House	ive street and number)			Pockvil		Dealli			lontgomer	
	Funeral				e (In yrs. I	ast birthday,			Min.	8. Date of Bir (Month, Da	rth	9 Birth	pplace (State or Foreign intry)
	Director		216-40-5568	1□ M 2□ F	66	Yrs.	Wichtins Days	Tiodis		Jan 28	3, 1		yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or L	ocation						10d. Inside City Limits
	MD Montgomery Damascus								1 ☐ Yes 2 XNo				
	h the	irec	10e. Street end Number			<u>upoup</u>	10f. Zip Code				10g. C	Citizen of What Cou	intry?
	th wit	Funeral Director	10828 Bellehaver				20872				USA		
	items	nue	11. Marital Status	12. Was Decedent B Armed Forces? 1 Yes 2 X	Ever in U.S	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Spec Puerto R	cify Yes or No lican, etc.))-	14. Race - Amer Black, White	
200	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:	10		1 □Yes 2 No	Specify:				Specify: Wh:	ite
5	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. fem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "nadical Examinating to notified."		15. Decedent's (Specify only highest	Education		16a. Dece	edent's Usual Occup	nation	of working	~	16b.	Kind of Business/li	ndustry
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7	led w Hygier her th		12 17. Father's Name (First, Middle, La	et)		Real	Estate A			(First, Middle		<u>al Estate</u>	3
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<u> </u>	shoul ind M ind M	ပ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mail	ing Address (Street						ip Code)
Ě	and 2 raith a r 27 is er trai		Nichole J. Reinh	old/daughte	er	2512	5 Seneca	View C	Ct. G	aither	sbu	rg, MD 20	0882
ב כ	of He		20a. Method of Disposition	☐ Removal from State	20b. P	lace of Disp emetery, cre	osition (Name of ematory or other pla	œ)	Da	ate	20c.	Location - City or T	own, State
	t. Pag tment tant; tant;		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		W.		el Cremat					enton, M	
<u> </u>	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the sonce.		21. Signature of Funeral Service Lie	ensee) //									
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	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each ling colon Ca									Onset and Death
	/Medical		resulting in death)	Due to (or as									
	Examiner	_	Sequentially list conditions,	b									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	derice or):							•
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0000	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	/edical		d									
5	ertifica ling pl e as t		IF FEMALE:	00. 16									
2	eath cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	I death 3	☐ Ectopic pregnand	у				23d. Date of deli Month	very Day Year
5	the d	Physician/I	1 □Yes 2 XNo 9 □ Unknown	9 Unknown									
Ų,	requires that the de been signed by the should be detached	by P	Part li. Other significant condition	contributing to death be	ut not resu	ulting in the	underlying cause giv	en in Part I.					the cause of death?
colors,	equire sen sig									1 🗆	Yes	2 □ No 3 □ Pro	obably 4X Unknown
ב	e law r has be	Completed								24a. Was	psy	prior to c	topsy findings available ompletion of cause of
<u> </u>	ilclan; The certificate ector, pag	-		7						1 ☐ Yes	ormed? 2 □X	death? No 1 □ Yes	2 🗆 No
5	siclar certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No	Hospital:	nt 2 🗆	SD/Outpatia	ent 3 DOA Oth			(Check only		e Mother (0	hospice
	g Physer this eral dil	n: To	27. Manner of Death	28a. Date of inju (Month, Da		28b. Time						jury occurred	my nospice
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<u>"</u>	or Attending Physician: The law required that death. Director: After this certificate has been s in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At ho c. <i>(Specif</i>	ome, farm, si	treet, factory, office		28	8f. Location City or To		and Number or Ru ate)	ral Route Number,
ב	pital o		29a. Certifier 1X Certifying	Physician: To the best	of my kno	wledge dea	ath occurred at the t	ime date and	d place, a	and due to the	e cause	(s) and manner as	stated.
	e Hos	Medical		aminer: On the basis o	f examina								
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							, Day, Year)				
			Grenene	Mobile	WSI	5° 00) D646	15			Ap	ril 3, 20	009
(ı.	5)00		30. Name and address of person w Genevieve Wroble					Na ∫	Pool	villa	M	20855	
V		te	31. Date filed (Month, Day Year)	32. Pegistr			ADUCE PILL	- IW.	TOCK	^ TTTE	לוניז	20033	

Physicia /Medic Examin

Funeral Director

1 - For State Registrar	Otato of Ma	Ce.	rtificate of		-	. No. 2009	12794			
1. Decedent's Name (First, Middle, Last)	. n .	1			Date of Death Month	Day Year	3. Time of Death			
Joseph L 4a. Facility Name (If not institution, give s		d	41- 02- 7	. Leasting of Death		24, 2009 4c. County of Dea	3:32 P. M			
6527 Livingston R	,	202	Oxon	r Location of Death Hill		Prince (
5. Social Security Number 6. Sex 577–44–5444		(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,) September	ear 1936 9. Bir	thplace (State or Foreign through the state of the state			
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
Maryland Prince G	eorges	0xon	Hill				1 X Yes 2□No			
10e. Street and Number			10f. Zip Code		100	. Citizen of What Co	ountry?			
Maryland Prince Georges Oxon Hill 10e. Street and Number 6527 Livingston Road; Apt. 202 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Last) 10g. Citizen of What United Status 10g. Citizen of What United Status 110g. Citizen of What United Status 110g. Citizen of What United Status 12e Value Complete 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W Specify: In Indian India										
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Event Armed Forces? 1 X Yes 2 □ Note of Yes, Give Year or Dates:)	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No- pecify Research pecify Resea	14. Race - Ame Black, Whit Specify: B]	e, etc.			
15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of world	king 16	b. Kind of Business	/industry			
Elementary/Secondary (0-12) 10th grade	College (1-4or 5+))	Cab Driv		7	axi Cab (Company			
17. Father's Name (First, Middle, Last)		I.		18. Mother's Nam	ne (First, Middle, Ma	iden Surname)				
Charles Reid				Cora	Smith					
19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number, C	City or Town, State,	Zip Code) 20745			
Virgie Lynn Rich	Reid (Wife	, 			-	con Hill,				
20a. Method of Disposition 1 Rurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	,		Chelten	nam Veter	1 7,2009 ans Cemet	ery Ma	ltenham, ryland			
21. Signature of Funeral Sorvice License	3. Hent						Morticians on,D.C.200			
23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Insulin Dependent Diabetes Mellitus Due to (or as a consequence of): Chronic Renal Insufficiency Due to (or as a consequence of): Chronic Renal Carcinoma										
resulting in death) Last										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions com Peripheral Arter 25. Was case referred to medical examiner?	23b. Was decedent pregnant in the past 12 months? 1									
Part II. Other significant conditions com Peripheral Arter	•	_	nderlying cause giv	ren in Part I.	1		the cause of death?			
					1					
					24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of : 2 □ No			
25. Was case referred to medical examiner?					th (Check only one)					
To les EMINO	ospital: 1 ☐ Inpatien			4 LI Nursing He		ce 6 ☐ Other (Spe	cify)			
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. Time o	Wor	ryat k? Yes 2 □No	28d. Describe how	injury occurred				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,			
29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin		examination and/or in								
29b. Signature and fittle of certifier	lens	MA	29c. Licens	se number	(111)	Date signed (Mont	h, Day, Year) 2009			
30. Name and address of person who con	mpleted cause of dea	ath (Item 23a) (Type.	Print)	1110/1	1+		20770			
				r Drive:S	Suite 115:	Greenbelt	,Maryland			
31 Date filed (Month, Day, Year)	32. Registrar	s signature		. ,						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 0840 A-M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex Hours Months Days 1 ☐ M 2 🕮 F Pennsylvania Jan. 4, 1945 303-48-4140 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 21 No Colonial Beach Westmoreland Virginia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22443 United States 176 Darl Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Jane Price Harry Bowen Hunt, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 176 Darl Circle, Colonial Beach, VA 22443 (Husband) Dennis C. Stutzel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/5/09 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Euneral Service Licen 10 East Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 20a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ntrace disease or condition resulting in death) Due to (or as a consequence of): rencer a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

this

After

death. spital or Attendi lours after death. neral Director: A

To the Hospital o

funeral (

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Motion Exeminer must be not the an

and Mental Hygiene.

Department of Health a Important: If Item 27 is any injury or other trau

Pages

with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Examine attending physician and for use as the burial-tran Physician/Medical cate has been signed by the page 2 should be detached 2 Completed his certificate I Be Certification: To

IF FEMALE: 23b. Was decedent pregnant

27. Manner of Death 1 Natural 2 Accident

29b. Signature and title of certifier

5 ☐ Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

medical Centerpr.

name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

SWILL MA

State Registrar

Medical

31. Date filed (Month, Day, Year)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** \mathbf{a}^M 1:10 Elaine Mildred Shalowitz April 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Medical Center Prince George's Chever1v 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🕱 F Yrs Director Washington, DC 579-32-4319 80 May 03, 1928 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No **Maryland** Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3122 Gracefield Road, Apt. 108 20904 death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 72 hours after 1 ∐Yes 2 🕱 If Yes, Give Year or Dates: 2 😿 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: ð 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Professor** s 1 and 2 should be filed wir f Health and Mental Hygien Item 27 is marked other th 5+ Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Albert Langerman Shirley Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3122 Gracefield Road, Apt. 108, Silver Spring, Maryland 20904 Erwin E. Shalowitz - Husband other t permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) 04/07/2009 King David Memorial Gardens Falls Church, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failed e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final **Physician** Cardiac Arrhythmia 6 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure 6 weeks Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Aortic Stenosis 5 years attending physician and for use as the burial-tran Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Parkinson's Disease has page 2 autopsy performed? 1 □ Yes 2 🗷 No certificate Pneumonia 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ko 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A
httplicely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar

APR 06 2009

Revathy Murthy, M.D.,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

33 Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

6130 Landover Road, Cheverly, Maryland

D16273

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DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

32.

8 2009

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 April Physician 4, 7:08 P M Jane Bonsa1 Shipley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Vantage House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min Hours 1 □ M 2 🗓 F Yrs. 1920 Maryland 89 Jan 26, Director 218-10-9481 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show iner must be notified at 1 □Yes 2√2 No Funeral Director Columbia 28a-f MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21044 USA 5400 Vantage Point Road #414 or items 23a 13. Was Decedent of Hispanic Origin? (Specify Ye's or No-lf Ye's, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: White traumatic event, the Medical Exam Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fil and Mental H ' is marked ot Edith Turner Noah Columbus Main ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Kenneth Martin Shipley, Sr./son | 13508 Orion Drive Dayton, MD 21036 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arundel Crematory 04/08/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses G3147 TIOMESCIFEMATION Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks /Medical ovascu i Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. t □Yes investigation after death 3 Suicide 6 Could not be determined 28e. Place of Injury - Athome, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar . Towsertaun Bud/Balt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Fatma Kameela Sesay 2009 03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring

Floder 1 Year | | f Under 24 Hrs. | Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Min. 1 □ M 2 🖾 F Yrs Silver Spring, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Exerciner must be notified at 1 M Yes 2 □ No Directo Prince George's Landover Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 3101 75th Avenue, #303 20785 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify. Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+)
Infant Never Worked permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If item 27 is marked other the any injury or other traumatic event, that once. Never Worked Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Stanley Khadija Sesay ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 75th Avenue, #303, Landover, MD 20785 Khadija Sesay / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 4/4/2009 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. elus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Hypoplasia 5 Days /Medical Due to (or as a consequence of): **Examiner** 5 Days Thanatophoric Dysplasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the aftending physician and filled in by the functoral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, of Vital Records. Division

Certification

Completed	
Com	
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
=	27. Manner of Death

Medical

7. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Homicide

24 hours

State

29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number D23200

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 30-00

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

2 **₩**No

2 **V**No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day, Year)

Janel Kelly Hino, 1500 Forest Glen Road, Silver Spring, MD 20910

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1150 PM 200 nelma 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Boonsboro, If Under 1 Year | If Under 24 Hrs. Fahrney Keedy Memorial Home Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Months Days Hours 577-42-1372 1 □ M 2 😾 F 79 12/30/1929 DC Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a State 10h County 1 →Yes 2 □ No Montgomery Wheaton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12713 Feldon Street .S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🖺 No Specify. Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Η. George Noble Susan Caldwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph R.Scheffer Jr./ Son Station Terr. West Martinsburg, West VA, 25403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft.Lincoln Crematory 04/09/09 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses Du 3401 Bladensburg Rd.Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that outset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final em ent disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Dus to (or as a consequence of) any, leading to minedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown leath? Unknown available ause of

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be retilified at once.

Saltimore, Maryland 21215-0036

Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit

Physician/Medical <u>Ş</u> Completed Be Certification: To I or Attend after death Director: To the Hospital or within 24 hours at To the Funeral D Medical

Division of Vital

Part II. Other significant conditions o	23e. Did tobacco use contribute to the cause of c	
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐
		24a. Was an autopsy performed? 1 □ Yes 2 ☑No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☐ Ôlo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	f. Location (Street and Number or Rural Route Num City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Waseem 1126 Opal Court Hagerstown, MD 21740

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. 3. Time of Death **Physician** 1834 Sigur Mary Clare Rosarii /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner -12NTON If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, August 31 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 218-56-5810 1 ☐ M 2XXF 55 Director Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Prince George's Clinton 4 1 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 6511 Horseshoe Road 20735 23a Funeral USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. items 2 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 TNNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ∐Yes 21∭XNo Completed by Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Piano Teacher 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas John Rowland Mary Clare Killeen ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 i y or other tra Gaston Sigur / Husband 6511 Horseshoe Road Clinton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Resurrection Cemetery 04/14/2009 4 ☐ Donation 5 ☐Other (Specify) Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature uneranService Lizensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Palt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy s been signed by the atter should be detached for in the past 12 months? Month Day Year 1 ☐Yes 2 ☐No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has that all director, page 2 s 2 🗆 No 1 □Yes 2. No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1. Natural 5 Pending investigation after death. 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 62

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dav <u>a</u>^M **Physician** 4/4/2009 1:15 EDWARD H. SCOTT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEROGE"S PRINCE GEORGE"S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min 1 🕱 M 2 🗆 F 9/11/1954 Washington, 577-76-1994 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1XIYes 2 ☐ No Director Prince George's Fort Washington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20744 9005 School Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ∐Yes 2 🕱 No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Maintenance Supervisor</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Scott Katie Gross ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 9005 School Way Fort Washington, Maryland 20744 <u>Jacqueline Scott / Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/11/2009 4 ☐ Donation 5 ☐ Other (Specify) Washington National Suitland, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service II censee 401055 5538 Marlboro Pike Forestville, Maryland 20747 Turky 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or w consequence of): 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2100 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No

be executed Box 68760. P.0. Division of Vital Records,

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Pages 1

Department of Health Important; If item 27 any Injury or other troone.

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Maryland 21215-0036

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or Attending Physiclan; The law requires that the death certificate after death. Hospital

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State Registrar

6 ☐ Could not be

determined

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

TEXCERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ress of person who completed cause of death (Item 23a) (Type, Print)

31. Date file

29b. Signature and title of certifier

3 🗌 Suicide

29a. Certifier (Check only one)

4 - Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 3:00 РМ Lyndia Creager Self 2009 April 4, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Casey House of Montgomery Hospice Montgomery Rockville 8. Date of Birth (Month, Day, June 5, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days 63 1945 213-44-4146 Vincennes, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1⊠Yes 2 No Maryland Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20639 USA 5720 Warren Drive Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Treasurer Omega Systems Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna L. Simpson Lyle Creager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5720 Warren Drive, Huntingtown, MD 20639 Sterling Self / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/7/2009 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Years Metastatic Adenocarcinoma of Vagina disease or condition resulting in death) Due to (or as a consequence of) 3 Years Adenocarcinoma of Vagina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Department of Health ar Important; if item 27 is any Injury or other trau

Physician

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Examiner

Funeral

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7 is marked other than "natural", or traumatic event, 11s. Medical Expt.

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-tran attending pl s been signed by the should be detached certificate has I rector, page 2 s Director:

Physician/Medical Examine Medical Certification: To Be Completed by

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral D completely filled i

State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic		23d. Date of delivery Month Day Year		
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow		
				24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No		
25. Was case referred to medical		eath (Check only one)				
examiner? 1 ☐ Yes 2 🎛 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆 D	ne 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ∐Yes 2 ☐ No	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29c. License number

D21531

29d. Date signed (Month, Day, Year)

4/8/2009

Registrar

12

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Marie Sitzenkoph 2009 10:55 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton 8. Date of Birth (Month, Day, Year) 5 – 1 – 1913 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours Min. 95 190-07-2720 Pa Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Evar. Inc. rust be redified at Talbot Easton Md Director 1 □Yes 2 □XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other traumatic event than "natural" or other traumatic event than "natural" or other traumatic event than "natural" or other trauma USA 21601 7178 Traverlers REST ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: 1 □ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Beaution 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Beck Charles Ouchtor P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7178 Travelers Rest Rd. Easton, Md. 21601 19a. Informant's Name/Relationship (Type. Print) Maryan Ramey (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Capitol Crematory 3-8-2009 Dover, De 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R. Carroll Hurley Funeral Home, PC
P.O. Box 518, St. Michaels, Md 21663 21. Signature of Funeral Service Licensee titt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acrote Cereprovascular Acecount 126/2009 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physiclan: The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 5 Other (specify) ned by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, sign I be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform his certificate to I director, page 1 ☐ Yes 2ÆÑo 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				epartment of Health and	Mental Hygie	ne
			• Registrar	Certificate of Death	Reg.	No. 2 U 3 2 SU 5
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	2009 Year 12:15P. M
	/Medic	al	Troy Kunimi Terawaki 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
7	Examin	er	11814 North Lincoln Avenue	Beltsville		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth	9. Birthplace (State or Foreign
	Director		575-47-9245 ¹\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	'S. Morturs Days Hours Will	June5,19	89 Həwəli
7	2		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
April	f sho	5	Maryland Prince George's Beltsvl			1 ☐ Yes 2 ☐XNo
4	28a-	rec	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	23a ol	a D	11814 North Lincoln Avenue	20 7 05		United States
1	nin 72 nours arter deain with me maryland an "natural", or items 23a or 28a-f show Midical Examinat mat be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	 Race - American Indian, Black, White, etc.
ဂ္ဂ	or it	by Fu	T∑ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ No If Yes, Give 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: Hawaiian
		ed b	15 Decedent's Education 16a. [Decedent's Usual Occupation		b. Kind of Business/Industry
Ċ i	within 72 iene. than "na fa Madio	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)		
7 7	d with giene er tha	ĕ	12 1 Stu	dent		Education
	be riled wit ital Hygien id other th event, Ins	Be (17. Father's Name (First, Middle, Last)	1	_{me (First, Middle, Mai} 9 De l o Sant	
ya ya	ould be 1 Mental marked o	၉	Marvin S. Terawaki	Mailing Address (Street and Number or F		
Maryland	traum					sville, Maryland20705
O	1 and Healt tem 2			Disposition (Name of crematory or other place)		c. Location - City or Town, State
altimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic evonce.				/4/2009 A]	Lexandria, Virginia
	oartm Sortar Injur		21. Signature of Funeral Service Licensee	Bonard ddress of Eacility		
ă			Monald WBnyward	4400 Powder Mill I	Road Beltsv	ville, Maryland 20705
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardi	ac or respiratory arrest	
	hysician			olar Rhabdomyosarc	oma	Onset and Peath 2 months
	/Medical Examiner		resulting in death) Due to (or as a consequence of	f):		
		er	Sequentially list conditions, The monotone because of the beautiful because of the beautiful because of the beautiful because of the beautiful be);-		
)	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
oʻ.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	E	resulting in death) Last Due to (or as a consequence o	():		
8760,	hysic the bu	dical	d			
o ×	ding p	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	eath certific attending p	Physician/Me	in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)		Month Day Year
0	the d by the sched	ysi	1 Yes 2 No 9 Unknown			
.,	w requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?
ğ	equire en sig ould b	ed			1 ☐ Yes	2X No 3 Probably 4 Unknown
င် မ	law re las be 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	cate h	S			performe 1 □Yes 2	d? death? No 1 □ Yes 2 ▼No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	sictan: The Is certificate ha irector, page 2	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	eath (Check only one)	
Division of Vital Records,	Phys rthis ral dir	은	27. Manner of Death 28a. Date of Injury 28b. T	patient 3 DOA 4 Nursing	28d. Describe how	ce 6 ☐ Other (Specify) injury occurred
on :	ttending Phydeath. stor: After thi the funeral (ţi	1 XNatural 5 □ Pending (Month, Day, Year) Ir 2 □ Accident investigation	ijury Work? M 1 ☐Yes 2 ☐No		
Visi	Aftendl er death. ector: A by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
<u> </u>	ital or rs afte al Dia led in	Ser				
	Hospi 4 hou Funer tely fil	ical	29a. Certifier (Check only Medical Examiner: On the basis of examination and	, death occurred at the time, date and pla d/or investigation, in my opinion, death oc	ace, and due to the cau curred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	one) and manner stated. 29b. Signature and title of Solitier	29c. License number	290	I. Date signed (Month, Day, Year)
	FZFÖ		W Xa	D05-951		April 3, 2009
	_		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
			Jeremy Edwards, M.D. 6900 Georgia	Avenue, N.W. Washin	gton, D.C.	20307
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	harded.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 12806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2009 April 4, Carolyn Holloman Troupe 12:58 A^M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda

Tender 1 Year | If Under 24 Hrs.

Min. <u>Suburban Hospital</u> Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) Months Days Hours Min. 1 □ M 2 🖫 F 578-62-2226 95 15, 1913 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits District of Columbia Washington ty∑ty'es 2 ∐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2512 Q Street, NW #207 20007 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: Black 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8+ years (1-4or 5+) Educator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. S. Holloman Rosa Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Deleware Avenue, SW Washington, DC 20024 Grace Holloman Davis - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Parial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Lincoln Memorial Cemetery April 11, 2009 Suitland, MD</u> 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Edema disease or condition resulting in death) Due to (or as a consequence of): Cardio Myopathy Sequentially list conditions, if any list in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe Ventricular Heart Disease Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pneumonia, Acute Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

death certificate be executed sician and burial-trans 68760 attending pl Box signed I Records, page 2 should certificate Vital After this certification funeral director, i ot Hospital or Attending Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examine Physician/Medical Be Completed by Certification: To Medical

Physician

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at

s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th other traumatic event, Its

Department of Heattl Important: If item 27 any injury or other to once.

Physician

/Medical

Examiner

Pages 1

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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/Medical

10a. State

Director

Funeral

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Completed

Be မ

Cardiac Arrhyth	nia	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
			1 □ Yes 2 V No	1 ☐ Yes 2 ☐ No						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 Yes 2 No	Hospital: 11 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	ursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	njury at Vork? □Yes 2□No	3d. Describe how injury	occurred						
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		ctory, office 28f. Location (Street and Numb City or Town, State)		d Number or Rural Route Number,						
29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	Physician: To the best of my knowledge, death occurred at the milner: On the basis of examination and/or investigation, in rand manner stated.	e time, date and place, ar ny opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)						

29c. License number

D17656

29d. Date signed (Month, Day, Year)

April 5, 2009

PBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tipaporn Woodward 5530 Wisconsin Avenue #550 Chevy Chase, MD 20815

Registrar

ate filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4/1/2009 11:52 MARTHA MAGDALENE TODD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 ☐ M 2√2 F Yrs. 12/25/1947 Washington, DC Director 578-66-6637 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", and item in the notified at ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 1 X Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21703 1215 Rutlegde Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 2K No 1 Never Married 2 Married Specify:Black 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Saic Glassware Processor 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarice Stephens Hastings Peter Todd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1215 Rutledge Place Frederick, Maryland 21703 Martin Todd / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/8/2009 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown BREAST CANCER Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Ves 2 2 No has 1□ Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ို To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4/3/2009 Melina MD 51610

Registrar
DHMH 17 Rev 1/2001

State

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1475 Taney Ave Frederick, Maryland 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tolino MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Ce	ertificate of			eg. No.		
	Physici	an	1. Decedent's Name (First, Middle, MARTHA THOM)	•				2. Date of Deatl Month	Day C UY	0.9 3. Time of Seath 0.9	
~~1	/Medic		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death	PRIL	1 20 4c. County of		
		Ĭ	ANNE ARUNDEL M			ANNAPC		Detect Dist		ARUNDEL	
	Funeral Director		218-16-3079	. Sex 7. Ag	e (In yrs. last birthda) 86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 4/6/1	Year) 9 2 2 1	D. Birthplace (State or Foreign Country) MARYLAND	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits	
	e Mari Ba-f sh	ctor	MD ANNE AI	RUNDEL	ANNAPOL					1 X Yes 2 □ No	
	with the sa or 2 the mo	Funeral Director	10e. Street and Number 1454 .FAIRFIELI	LOOP RI)	10f. Zip Code 21032		10	0g. Citizen of Wha	at Country? D STATES	
	death	ınera	11. Marital Status	12. Was Decedent Armed Forces?			Hispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	14. Race -	American Indian, White, etc.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may hiury or other traumatic event, the Medical Eventine must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced		No	1 □Yes 2√€ No	Specify:		Specify:]	BLACK	
21215-0036	within 72 h lene. than "natu h	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Giv	edent's Usual Occup re kind of wark done . DO NOT use retire	during most of working		16b. Kind of Busir	ness/Industry	
	filed wit Hygien other the		12 17. Father's Name (First, Middle, La	et)			DOMESTI 18. Mother's Name		DOMES	ric	
land	should be find Mental Find Men	To Be	NOBLE MACKALI	•			EMMA J	•			
Maryland	2 shou and N is mai		19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	iling Address (Street	and Number or Rura	Route Number	, City or Town, St	ate, Zip Code)	
	s 1 and 2 and 1 and 2 and 1 an	12	CHARLENE MACE 20a. Method of Disposition	CALL/NIECI	20b. Place of Dis	DOUGLAS position (Name of	ı Di	ELLE,	NJ. 072 20c. Location - Ci	2.0.3 ty or Town, State	
mol	Pages nent of ant: If its ury or o		1 □ Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			ematory or other pla ΓΕΚΑΝ CE	:	09	CHELTEN	NHAM, MD	
Baltimore,	permit. Departr Importa any Inju		21. Signatule of Funeral Service L	0 0 000	16 11	22. Name and Addre	CAPI	TOL MO	RTUARY	20002	
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W.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	aceveb	ul Her	new hage	٠		Offset and Death	
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	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.								
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68760,	cate be ohysicia the bur	Medical		d							
Box 6		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		D∏Satonia avegnon			23d. Date	23d. Date of delivery	
o.	0 0	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant a		B ☐ Ectopic pregnand D Other (specify)	С		Monti	h Day Year	
rds, P.	requires that the de been signed by the a hould be detached f	þ	Part II. Other significant condition	s contributing to death b	nut not resulting in the	underlying cause give	ven in Part I.	23e. Did tot		ute to the cause of death?	
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ŧ ∠ii	Physicia this cert al directo	o Be	examiner?	Hospital:	ent 2 ☐ ER/Outpat	ient 3 DOA Otl	26. Place of Death ner: 4 ☐ Nursing Hor		ence 6 □Other	(Specify)	
o uc	Attending Physician: The rideath. ector: After this certificate hey the funeral director, page	ion:	27. Mann Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay, Year) Injury	/ Wo	ry at 2 rk?]Yes 2 □No	8d. Describe ho	ow injury occurred		
Division	or Atten after deatl Director; in by the	Certification: To	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At home, farm, s ic. (Specify)			8f. Location (St City or Town		or Rural Route Number,	
_	the Hospital hin 24 hours of the Funeral mpletely filled	Medical Co		Physician: To the best kaminer: On the basis and manner si	of examination and/or						
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	,	<				Does	55291		4/1/2	007	
	5		30. Name and address of person w	4 4	death (Item 23a) (Typ	e, Print) e Avunde	l Med Con	In it	Inapoli	5 21401	
	Sta Registi		31. Date filed (Month, Day, Year)	a. Plegist	rar's Signature	upla 9					

DHMH 17 Rev 1/2001

ORIGINAL

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Melissa Vanderhoe		n S For State	tate of Mary	/land / D)epartr	ment of icate of	Health	n and	Menta	al Hyg		Dec No	2	0.0	9 1280
	R	egistrar . Decedent's Name (First, Mide	dlo Last\		Certin	cate or	Deain				Date of De		-	3.	. Time of Death
Physician Medical Examine		Melissa Vande								N	Month March 30), 2009	Year		2143 hrs
Medical Examine		a. Facility Name (if not instituti	on, give street and	number)		4	b. City, To	wn, or L	ocation of	Death	4c. County of		-		
(5519 Galestown-Nev					Galest	own				- 1	orchester		
Funeral	5	. Social Security Number	6. Sex	7. Age (I	n yrs. last l	birthday)	If Under		If Under		B. Date of E	Birth (MM/	DD/YYYY) 9	Birthp. Count	lace (State or Foreign try)
Director		221-60-2790	1 M 2	≰ 34		Yrs.	Months	Days	Hours	Min.	1-12	-197	5	De1	aware
	t	Jsual Residence of Decedent												1	0d. Inside City Limits
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death or ite	\$		1 Ye	es 2 X	No		Yes 2	XNo	opocify:				Specify: V	Nhit	:e
after ral".		Α	Divorced If Yes, Give or Dates:		otod) 16	6a. Deceden				and of wor	rk done	16b.	Kind of Busir		
hours matur	<u>8</u> -	15. Decedent's Education (Special Elementary/Secondary (0-1:		ge (1-4 or 5+)		during m	ost of worl	king life.	DO NOT	use retired	d)				
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Me Me S	2	19a. Informant's Name/Relatio				19b. Mailin	Address	(Stree	t and Num	ber or Ru	ral Route N	Number, C	City or Town,	State, 2	Zip Code)
MD nd 2 sho alth and m 27 is aumati		Lucille Vand	er Hoeve	n 							Date		e. 199		own State
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Baltimore, pernit, Pages I an Department of Hea Important: If ite injury or other tr	t	21. Signature of Funeral Servi	ce Licensee			22.	Name and	Address	of Facility	Diah	aroor	FE	700	Wes	st ST. , De. 19956
w a s a li ii	k	HollyShor	toWar	nugan	<u> </u>	Ina	mint 8	dill, o	nor C	ordiac or i	respiratory	arrest sh	ock or hear	rel,	Approximate Interval
Physician		23a. Part I. Enter the disease, failure. list only one cau	or complications to use on each line.	hat caused th	ne death. L	o not enter	ne mode	or dyirig,	Sucii as c	arulac or i	r capitator y	arroot, c.	10011, 01 110		Between Onset and Death
'M-dical aminer	1	Immediate Cause (Final disea	36 a.	Pneumo						_		_		- 2	
	-	or condition resulting in death	Due to (or	as a conseq	(uence of):										
	F	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consec	uence of):										
	틝	cause. Enter Underlying Cau	the G.					11				_			
ed sit	Examine	events resulting in death) La	st Due to (or	as a consec	quence or):										
executed ian and ial - transi	edical	UNPENDED	dAMENI	DED.											
				yes, outcom	e of pregna	ancv				-		12	23d. Date of	delivery	
Box 6876 e death certificate the attending phy	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	in the 1 1	Live birth		2 F	etal death	3	Ectop	ic pregnar	псу	- 1	Month	D	ay Year
x 6 th cer th cer trendi	Sicial	1 Yes 2 No 9	University	Pregnant at t	ime of dea	th 5 C	ther (Spe	ecify)				- 1			
Bo ne dea the a	hys			Unknown ting to death	but not res	sulting in the	underlyin	g cause	given in P	art I.	23e. D	oid tobacc	co use contrit	bute to t	the cause of death?
P.O.	by F	Part II. Other significant cor	iditions contribu	ing to death	Dut not rec	salang in the	una on y m	9 00000	3		1	Yes 2	No 3	Prob	oably 4 🗸 Unknown
S, F puires an sign										_		Vas an	24b. W	vere au	topsy findings available
ord Iw rec as bee	Completed										p	utopsy erform <u>ed</u>	i? d	eath?	completion of cause of
Rec The la	mo:							_				es 2	No 1	✓ Ye	es 2 No
Vital Reorgysician: The this certificate director, page	Be	25. Was case referred to me examiner?	dical Hospital:						of Death		g Home 5	Pos	idence 6	Other	r: Scene
Vit hysic	10	1 ✓ Yes 2 No		Inpatier		ER/Outpatie 28b. Time o		DOA	ury at Wo				injury occurre		
fing Ph After t funeral		27. Manner of Death 1 X Natural 5		Date of Injui (Month, Day,Ye		28b. Title 0	i injury		Yes 2	_					
sior ttend death ctor; y the	atic		Pending Investigation	e. Place of Inj	ium. At ho	me form et	eet factor				28f. Locat	ion (Stree	et and Number	er or Ru	ural Route Number, City
Division of Vital Records, red or Attending Physicien: The law requir rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:		Could not be	e. Place of Inj pecify)	ury - At 110	me, ram, su	eet, lactor	y, 011100	Danamy,			wn, State			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		4 Homicide	Di visioni Toti	he heat of mi	knowledg	e death occ	urred at th	ne time (date and r	lace, and	due to the	cause(s)	and manner	as stat	ed.
he Ho in 24 l	ical	(Check only 1 Certifyin	Examiner:On the	basis of exar	mination ar	nd/or investi	gation, in r	ny opinic	n, death	occurred a	at the time,	date and	place, and d	ue to th	ie cause(s)
To the virthing To the company	Medical	29b. Signature and title of ce	and ma	nner stated.		.			nse numbe						onth, Day, Year)
		m, 20	1/1001	Da 11-				0.0	.M.E.			Ν	larch 31,	2009	
200		30. Name and address of pe	rson who complete	ed cause of d	eath (Item	23a)									
190			Assistant Med			111 Peni	Street	, Baltir	nore, M	D 2120	1				
9	tate				r's Signatu	ire /	arks	1							
Regis		A	18 2009	Lenn	m ,	p. 4	and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Tor State	Certificate of Death	и мена пу	Reg. No 2 0 0 9	12810				
Physi		LITTE MCG "O.		2. Date of De		3. Time of Death 1725 м				
/Med Exam		A. E. W. M (If a distriction of standard number)	4b. City, Town, or Location of E Silver Spri	Death ing	4c. County of Death					
Funera Directo	_	5. Social Security Number 241-58-4539 6. Sex 1 M 2 🔀 70	t birthday) If Under 1 Year If Under 24		ay, Year) Cou	place (State or Foreign intry)				
0		Non-the Ci	Town or Location lver Spring			10d. Inside City Limits 1 □Yes 2 K No				
with the 3a or 28	Dire	10e. Street and Number 13920 Castle Blvd. #501	10f. Zip Code 20904		10g. Citizen of What Cou USA	ntry?				
ING Z IZ 13-UU30 be filed within 72 hours after death with the Maryland fairly bylene. ad the than "natural", or items 23a or 28a-f show event, the Medical Eventings mast be notified.	by Funeral Director	If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Specify:	etc. Black				
IZID-U	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most o life. DO NOT use retired) Teacher	f working	New Yor Public Sc	k City				
aryland 2121 should be filed within and Mental Hygiene. s marked other than "	To Be Co	17. Father's Name (First, Middle, Last)	1	s Name (First, Middle el Clemo						
M hd 2 alth 2 27 is treat	-	19a. Informant's Name/Relationship (Type. Print) sons/ Jonathan and Terence West	19b. Mailing Address (Street and Number 13920 Castle Blv	d.#501 S	ilver Spri	ng,Md20904				
ant: Fa		1 Burial 2 M2 Cremation 3 Hemoval from State 4 Donation 5 Dother (Specific)	ce of Disposition (Name of netery, crematory or other place) esapeake Crem. 4/	02/2009	Beltsvill	e,Md				
Dait permit. Departi Importa	once.	21. Signatur & Funeral Septice of usee	PHTETPADSRENA 9241 Columbia	Blvd.Si	lver Sprir	ig, Md20910				
fiffcate be executed the executed by the polysician and as the burial-transit	al er or	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
P.O. BOX that the death certified by the attending letached for use as	Dhusioisi Modicio		leath 3 ☐ Ectopic pregnancy ath 5 ☐ Other (specify)	23e. Did	23d. Date of del Month	Day Year				
ords, quires to en signe uld be o	1 4 50	An and an		10]Yes 2 1 KΩNo 3□Pr	obably 4 Unknown				
I Rec The law ate has t	to and			perl 1 □ Yes	opsy prior to death? 2 ☑ No 1 ☐ Yes	atopsy findings available completion of cause of 2 □ No				
Vital F siclan: The certificate irector, pag	á	25. Was case referred to medical examiner?	Other:	of Death <i>(Check only</i> sing Home 5 ☐ Res	one) sidence 6 ☐ Other (Spe	cifv)				
Division of Vita within Edward of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director;	1		28b. Time of Injury at Work? M 21 □ Yes 2 □ N	28d. Describe	how injury occurred					
DIVISION Attender des In Director	1	4 ☐ Homicide determined building, etc. (Specify)		City or To	(Street and Number or Re own, State)					
E Hospital or 24 hours a e Funeral I		29a. Certifier (Check only one) 1 ★Certifying Physician: To the best of my know 2 ★ Medical Examiner: On the basis of examination and manner stated.	rledge, death occurred at the time, date and on and/or investigation, in my opinion, deat	d place, and due to the h occurred at the time	e, date and place, and due	e to the cause(s)				
To the within 2 To the comple	P	29b. Signature and fitte of pertifier	29c. License number D 6 7 5 8 9		29d. Date signed (Mont	ካ, Day, Year)				
			Forest Glen Rd.	Silver S	pring,Md 2	0910				
Reg	State istra	31. Date filed (Month, Day, Year) APR 06 2009 Sentus S.	pares.							

DHMH 17 Rev 1/2001

09-02793 Lar

rry Wilson		Please Type or Print in Black Indeli State of Maryland / Departm			ible.		
,		1- For State Certific	eate of Death		.No. 2009 1281		
Physici edical Exam		1. Decedent's Name (First, Middle,Last) LARRY DEAN WILSON		Date of Death Month	3. Time of Death		
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deati	April 7, 200	4c. County of Death		
		Howard County General Hospital	Columbia		Howard		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bird 215-74-1986 1. V.M. 2 5 4.7	thday) If Under 1 Year If Under 24Hrs Months Days Hours Mir		(MM/DD/YYYY) 9. Birthplace (State or Foreign		
Director		I A IW Z F	Yrs. Days Hours Will	June 2	0,1961 Country) MD		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	•	10d. Inside City Limits		
and show nce.	<u>ا</u>	MD Howard (Columbia		1 XYes 2 No		
Maryl r 28a-f ed at o	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?		
ith the 23a on notifie		5974 Grand Banks Road	21044		U.S.A.		
eath w items ust be	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.		
after de al", or ner m	by Ft	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year		Specify: Black			
hours : natura	ed b		Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use ret	work done 1	16b. Kind of Business/Industry		
36 nin 72 e. Ihan "dical I	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Unemployed				
5-00 ed with lygien offher he Me	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	siden Surname)		
121(I be fil ental F arked	Be	beth Wilson					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	입	19a. Informant's Name/Relationship (Type, Print) Agnes E. Anderson (Mother)	b. Mailing Address (Street and Number or 5974 Grand Banks	Rural Route Numb	er, City or Town, State, Zip Code)		
e, M l and 2 Health item 2		20a. Method of Disposition 20b. Place of	of Disposition (Name of cemetery,		20c. Location - City or Town, State		
MOF Pages ent of int: If		1 Burial 2 X Cremation 3 Removal from State Accent	tory or other place) it Crematory 4/	13/09	Hanover, MD		
Salti ermit. epartm nporta jury o		21. Sign tup: of Funeral Service Lio Teee	22. Name and Address of Facility S N	OWDEN F	UNERAL HOME, P.A.		
Physician	97 ()	23a. Part I. Enter the disease, or compligations that caused the death. Do not	246 N. Washingt	on St, R	ockville, MD 20850		
/Medical		failure. List only one cause on each line.	ine) and alcohol int		Between Onset and		
vaminer		Immediate Cause (Final disease or condition resulting in death) a. NAFCOLIC (MOTPI) Due to (or as a consequence of):	ine, and arconor in	CATCALIO			
	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
0	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death.) Last Due to (or as a consequence of):					
e executed sian and ial - transit	Ex	d.					
), be exer sician a	dical	X UNPENDED AMENDED 23a,PII,27	,28a-f,perME, g890 4	/28/09 T	T		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. The law requires that the death. The law requires that the death. The law requires that the attending physician pletely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month Day Year		
ox 6 ath cert attendi	sicia	past 12 months?			Month Bay Four		
that the de ned by the detached f	Phy	3 OTINIOWI	g in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?		
ords, P.O. w requires that the as been signed by should be detack	d by	Atherosclerotic cardiovascular			2 No 3 Probably 4 V Unknown		
Records, The law require ficate has been si, page 2 should b	Completed			24a. Was an autopsy			
tal Reco cian: The law certificate has ector, page 2 sl	omp			perform 1 ✓ Yes 2			
ital Recision: The sector, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)			
of Vital ng Physician; After this certif	ပ	1 ✔ Yes 2 No Hospital: 1 Inpatient 2 ✔ ER/Ot 27. Manner of Death 28a. Date of Injury 28b.	utpatient 3 DOA Other Nursii Time of Injury 28c. Injury at Work?	ng Home 5 Re 28d. Describe ho	esidence 6 Other:		
Sion of variending Pludeath. ctor: After ty the funeral	tion	1 Natural 5 Pending (Month, Day, Yeár)	10 pm	unk	williary occurred		
Division tal or Attendii rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.	28f. Location (Str	eet and Number or Rural Route Number, City te) 8536_Storch Woods		
Divis Hospital or A 24 hours after Funeral Dire		4 Homicide determined (Specify) truck 29a. Certifier 1 Certifiers Physician: To the boot of my knowledge dec		Dr. Sav	age, MD		
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or in					
To To	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)		
	O.C.M.E. April 8, 2009						
		Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	111 Pann Street Politimers N	ID 21201	·		
St	ate			ID 2 120 1			
Regist		APR 18 2009 Deneus B.	parled				

DHMH 17 Rev 1/2001 OCME 2006

OCME

09-02826 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen M. Williams State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day April 9, 2009 0344 hrs Stephen Mason Williams Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 5781 Catoctin Vista Drive Mount Airy If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland
Country Months Days Hours Director 217-21-5754 27 1X M 2 03/19/1982 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h. County 10c. City. Town or Location Yes 2 X No Frederick Mount Airy Maryland death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 5781 Catoctin Vista Drive 21771 United States Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes I and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Specify: White Widowed 1 Divorced If Yes, Give Year Yes 2 X No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 Sales Representative Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jay Williams Sandra McDaniel Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771Baltimore, MD If item 27 is Jay Williams / Father 5781 Catoctin Vista Dr., Mount Airy, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 April 11 Burial 2 X Cremation 3 Removal from State Resthaven Crematory important; 2009 Frederick, Maryland Other Specify Donation 5 Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of F ice icense 23a. Part Enter the lisean, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line.

Approximate Interval **Physician** /Medical Death a Ingestion of unknown toxic substance Immediate Cause (Final disea xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical 23a,27,28a-f,perME, g894 8/2//09 TT physician X UNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. à Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 1 🗸 Yes Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending I within 24 hour after death. Certification: subject ingested substance Natural Yes 2X No 5 Pending Director: the Fd 4/4/09 Fd 3:00 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5781 Catoctin Vista 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be home (Specify) Mount Airy, MD To the Funeral 4 X Homicide ij 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe OGME April 9, 2009 O.C.M.E. Name and address of person who complete cau e of death (I m) 23a)

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year,

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Registrar's Signature

alled

To the

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State Registrar Jenny V Moy 13952 Baltimore Aue Laurel MD 20707

31. Date filed (Month, Day, Year)

APR 0 7 2009 Server S. park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43260

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Sherman Walker 4PRIL T., 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Hospital Prince George's Lanham 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number Sex 14D M 2□ F 7. Age (In yrs. last birthday) **Funeral** 1932 227-36-9973 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Model Event or other traumatic event, its Model Event or other traumatic event, its Model Event or other events. XXYes 2 □ No Director District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20017 United States 635 Edgewood Street, NE #618 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXVio Black Baltimore, Maryland 21215-0036 Specify. Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 years Laundry Worker Private 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie Walker Eliza Tenner ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Addison Road #138 Capitol Heights, MD 20743 Emma G. Washington - Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Lee's Crematory April 17, 2009 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sinnature of Funeral Service Line Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that cased the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ewhite ilcer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner brillahow burial-transi and resulting in death) Last Due to (or as a consequence of): physician sthe burial Box 68760. pe Physician/Medical signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 0 1 ☐ Yes 2 ☐ No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No □ Inpatient 2 ER/Outpatient 3 DOA မ 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi

23

State Registrar IZABETH

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAS

MDD 60925

LANHAM, MO 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 2815 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Williams Rosco 2:50 am arch 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City. Plata Medical Center If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 1 🕱 M 2 🗆 F Months Days Hours 72 248-56-5064 2/16/1937 SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Charles County Waldorf MD 1 ☐ Yes XXNo 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 USA 3605 Moses Way #310 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 X Married Specify: Black 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearline Bellamy Loris Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 Moses Way #310 Waldorf MD Martha Williams/ W 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2009 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State Riverdale MD April 4, Riverdale Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Dunn&Sons 5635 Eads St. NE Washington, DC 21. Signature of Funeral Service Licenses 23a. Perft. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. pertensin disease or condition resulting in death) or as a consequence of) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 [X]No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Physician: The law requires that the death certificate be executed and the burial-trai Division of Vital Records, P.O. Box 68760, attending physician for use as the buria certificate this or Attending

cate has been signed by page 2 should be detach after death Director: filled in by the Hospital Funeral

Physician

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

and 2 should be filed within ' lealth and Mental Hygiene. m 27 is marked other than "

Pages 1 ment of H

Department of Important: If it any injury or o

Physician

/Medical

Examiner

Baltimore, Maryland

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death with

Funeral Director

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

/Medical

State Registrar

DHMH 17 Rev 1/2001

Poockikians

29d. Date signed (Month, Day, Year) 03-31-2009

address of person who completed cause of death (Item 23a) (Type, Print)

Rd, Suite 3 Bladensburg, MD 20710

S632 Amapolis

and manner stated.

29b. Signature and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 4 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month 2148 Williamson Eugene 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Trince 6 con he If Under 1 Year | If Under 24 Hrs 5. Social Security Number (In vrs. last birthday . Date of Birth (Month, Day, Voar) 1**∑** M 2□ F 83 Months Days Hours 243-34-6519 Sept 17, North Carolina 1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Maryland Prince George's Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 101 Pelican Garth 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 1 Yes 2 □ If Yes, Give Year or Dates: 1 □ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years United States Postal Worker Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Elliott John Williamson 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Williamson Gordon 12502 Monterey Circle Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Department | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) ort Lincoln Cemetery April 11, 2009 Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 □ Yes 2 □ No 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Department of Important: If it any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Martal Hyglens are the state of the state of the than "natural", or items 23a or 28a-f shown it flow 27 is marked other than "natural", or items 23a or 28a-f shown any or other traumatic event, the Marical Exprining result for nutilisal at any or other traumatic event, the Marical Expringer result for a full flow and the contract of the state of the state of the flow of the state of the st

Baltimore, Maryland 21215-0036

Maryland

and burial-trar attending physician for use as the burla ned by the a cate has been signed page 2 should be det certificate director, this funeral After 1

Examiner Physician/Medical ş Be Completed Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after deatle Funeral Director: filled in by the pletely Je.

27. Manner of Death

1 Natural

2. Accident

5 ☐ Pending investigation

Division of Vital Records, P.O. Box 68760,

Veith:	Ž
36	
Sta	te
Registr	ar

edical

11/4,2009 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Road, Fort Creek Swann 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred WAS

Crossing

Crosswall o

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28b. Time of Injury

1814

Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department Certificat				giene Reg. No. 200	9 12817					
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, L</i> as <i>t)</i> Sarah Weeks			2. Date of Dea	Day 2009 ^{Ye}	ar 1210p M					
	Examin												
	uneral irector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8									
yland	how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
he Ma	28a-f s	Director	MD Anne Arundel Glen Bernie 10e. Street and Number 10f. Zip	- Codo			10g. Citizen of What	1 ☐ Yes 🏃 ☐ No					
th with t	23a or 3		337 Lindera Court 210				USA	Country					
5-0036 72 hours after death with the Maryland	of other than "natural", or items 23a or 28a-f show event, the Madical Experience must be rudified at	by Funeral	11. Marital Status 1 Never Married 1 Never Married 3 Notice 12. Was Decedent Ever in U.S. Armed Forces? 1 Notif Yes, Give X Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give X Year or Dates:	cify Yes or No- Rican, etc.)	14. Race - A Black, V Specify: E	American Indian, /hite, etc. Black							
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d Z1Z1	ygrene. ner thar t, the	Com	College (1-40r5+) Homemak	ker			own hom	ie					
- 0	rked oth	To Be	17. Father's Name (First, Middle, Last) Georges Saunders		18. Mother's Name Salome J	(First, Middle, oseph	Maiden Surname)						
, Mary and 2 shou	Department of regulation mental Important: If item 27 is marked any Injury or other traumatic events.		19a. Informant's Name/Relationship (Type. Print) Shelia Gotha/daughter 19b. Mailing Address 337 Linc	era.	nd Number or Rura Court G	Route Numbe Slen B	er, City or Town, Sta ernie, ML	te, Zio Code) 2 1 0 6 1					
altimore, rmit. Pages 1 ar	tant: If iten jury or oth		20a. Method of Disposition 1										
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VISION OF Attending Phyer death.	r After th	Certification: T	27. Manner of Death Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 2 28b. Time of Injury 28b. Time of In	28c. Injury Work?		e 5 Residence 6 Other (Specify) 8d. Describe how injury occurred							
or Atte	Directo in by th	ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	8f. Location (S City or Tow	3f. Location (Street and Number or Rural Route Number, City or Town, State)								
LIVISION OF VICAL To the Hospital or Attending Physician: Within 24 hours—fler dea.h.	To the Funeral Director completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.										
To th	To th	Me	29b. Signature and title of certifier 29c	c. License	number		29d. Date signed (M						
	5,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	02472	21		4/8/2009)					
ĺ.	3)		Syed Sadiq 14333 Laurel Bowie Rd. L	aure	el MD #2	08 207	708						
	Sta Registr		31. Date filed (Manth. Day Year) APR 08 2009 Secure 3. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** A^{M} 6:00 31 2009 Yoshioka March Minami Rubv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | Country) | California Social Security Number 7. Age (In yrs. last birthday, **Funeral** 571-09-4269 98 Months Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it a Medical Expression to the profiled at MD. MONTGOMERY ROCKVILLE 1X Yes 2 □ No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe 9701 VEIRS DRIVE 20850 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic excession. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Yes 2 T If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify \$ Specify: Japanese 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Science Writer Science 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms.Sylvia Yoshioka-Daughter 411 W. 48th St. #5FE, New York, NY 10036 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Metropolitan Crematory 4/4/09 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility 22.22-Wisconsin Ave., NW 21. Signature of Funeral Service Licensee Will Hysong 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiopulmonary Arrest **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit Exami Alzheimers resulting in death) Last Due to (or as a consequence of): Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy lor Day Year Month 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached to 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔯 No 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

executed and Box 68760, attending physician The law requires that the death certificate be P.O. of Vital Records, certificate s after death.

I Director: After this certifical
of in by the funeral director, p Division or Attending To the Hospital within 24 hours a To the Funeral C

death with the Maryland

15

filled in by

Brett Gamma, 31. Date filed State Registrar

4 Homicide

(Check only one)

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

determined

9901 Medical Center Dr., Rockville, MD 20850

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Sig

and manner stated

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D51980

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For	State of Maryland / Department of Health and Mental	Hygiene
State Registrar	Certificate of Death	Reg No

		for State Registrar	State of	waryian		artment r <i>tificate</i>			na ivie		JIENE leg. No.	2009	12819
Dharist		1. Decedent's Name (First, Middle,	Last)						2	2. Date of Dea Month	-	' Year	3. Time of Death
Physicia /Medic		Jean Cl	nristie	Arno1d	l	_				April			5:23 P ^M
Examin		4a. Facility Name (If not institution,	give street and num	iber)		4b. City, T	own, or	Location of	Death		4c.	County of Death	
		Genesis Health 5. Social Security Number		Se ¹		na Par					Arunde1		
Funeral Director			5. Sex 1 □ M 2 🗓 F	7. Age (In yrs. I	last birthday) Yrs.		Days	Hours	Min.	Month, Day	(Year)	Cot	place (State or Foreign intry)
		483-16-5478 Usual Residence of Decedent		87						July 3	1,19	21	Lowa
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filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, I.e. M. dical, Exarian in rust by in Ulfred and	Completed		5+	101 01)	Te	acher					P	ublic S	chools
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, It. M. dical Exa		19a. Informant's Name/Relationshi			19b. Mailin	g Address ((Street a	and Number	r or Rural I	Route Numbe	r, City o	r Town, State, Z.	ip Code)
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Depa Impo any l		21. Signal de di Funeral Service Li	068.	MOO	1057 1/	ona 1d	son	Funer	al H	ome &	Crem	atory,	P.A.
		23a. Part 1 Enter the disease, or c shock, or heart failure. List o	omplications that ca									Marylan	Approximate
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/Medical		disease or condition resulting in death)		rebrova or as a consequ		Accı	dent	;					years
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death e atte d for	Physician/N	in the past 12 months? 1 ☐ Yes 2 🕅 No	4 ☐ Pregn	irth 2□Fetal ant at time of d		Ectopic pre Other (spe		′			•	Month	Day Year
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e faw r has be je 2 sh	plet						71			24a. Was a		24b. Were aut	opsy findings available
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cian: ertific ector,	Be (25. Was case referred to medical examiner?						26. Place	of Death (Check only or			
ding Physician: The h. h. After this certificate h. funeral director, page	၉	1 Yes 2 No		patient 2	ER/Outpatien			4 LAL NUI	sing Home	e 5 🗆 Resid	ence 6	5 □Other (Spec	ify)
After After funera	ion	27. Manner of Death 1 Natural 5 Pending		f Injury n, Day, Year)	28b. Time of Injury		lc. Injury Work	?		ld. Describe h	ow injur	y occurred	
death death ctor: / the	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	of Injury - At ho	me form of	M		res 2 □ N	_	f Location (C	M 4	d Moork on a Div	- I Don't Market
after Direct	Certification:	4 ☐ Homicide determin	ed buildin	g, etc. (Specify	y)	set, lactory,	onice		20	City or Tow			ral Route Number,
To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier CertifyIng	Physician: To the	best of my know	wledge, death	n occurred a	at the tin	ne, date and	d place, ar	nd due to the	cause(s)) and manner as	stated.
he Hc in 24 i he Fu pletely	Medical	(Check only 2 Medical E	xaminer: On the ba and mann	isis of examina	tion and/or in	vestigation,	in my o	pinion, deatl	h occurred	d at the time,	date and	place, and due	to the cause(s)
To tl withi To tl	ž	29b. Signature and the of certifier	1		Mi	29c.		number	7	ا زـ	29d. Dat	te signed (Month	, Day, Year)
			/(/	7	1011		1)	50 1	125		4-	21-	2009
1		30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, I	Print)	11	1	1-11	/	11.	111	21108

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03013 2009 12820 State of Maryland / Department of Health and Mental Hygiene Harold L. Able, Sr. 1- For State Certificate of Death Rea. No Registra 3. Time of Death 2. Date of Death Decedent's Name (First, Middle Last) Physician/ Month Day April 15, 2009 1327 hrs Medical Examiner TOLE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1800 Block of Aiken Street If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Numbe **Funeral** oreign Min Months Days Hours Director Country) 05 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10b. County Yes 2 No 28a-f show once, timore Pages 1 and 2 should be filed within 72 hours after death with the Maryland (Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Numbe 23a or atrobe Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? Never Married 2 X Married 2 X No Yes Yes 2 X No specify: Yes, Give Year Divorced 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than the Medical than Baltimore, MD 21215-0036 mployed Brown ess; e Be (Street and Number or Rural Royn, Number, City or Town, State, Zip Code) 19b. Mailing Address MD 21228 item 27 is atonsville В 20b. Place of Disposition (Name of cemetery Method of Disposition crematory or other place) 2 Ξ **Y** Burial Cremation 3 Removal from State Department mportant ٦a Donation 5 Other Specify: 21. Signature of Funeral Service Lipegsee 0 Pila Balto, Nat'1 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Gouss Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical nttending physician a UNPENDED **AMENDED** the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death has been signed by the attending 2 should be detached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an certificate has been prior to completion of cause of autopsy performed? death? 1 🗸 No Yes 2 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this | ٩ 1 ✓ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot FOUND: Yes 2 V No Pending Director: Apr 15, 2009 1256 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 1800 Block of Aiken Street, Baltimore, MD determined (Specify) Alley 4 V Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

To the 1

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Carol Allan, MD

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 16, 2009

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		artment of F rtificate of I			gien Reg. N	711114	12821		
			Decedent's Name (First, Middle, La.	st)				2. Date of De Month	ath	ay Year	3. Time of Death		
	Physicia /Medic		Gary E.	Bish	юр			April	18,	2009	3:22 PM M		
	Examin		4a. Facility Name (If not institution, giv				Location of Death	1	4c. County of Death				
g de la companya della companya della companya de la companya della companya dell			Suburban Hospita 5. Social Security Number 6. S		last hirthdav	Bethe If Under 1 Year		8. Date of Bir		ontgomery 9. Birthi	place (State or Foreign		
	Funeral Director		215-66-6270	[™] M 2 □ F 49	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Jun. 1	1 , Year	r) Coul	MD		
	ъ		Usual Residence of Decedent	140-04	. T						10d. Inside City Limits		
	arylar show	'n	10a, State 10b. County		y, Town or L						1 ☐ Yes 2√ No		
	the M	rect	MD Montgome	ery Gait	thersb	10f. Zip Code			10g. C	Citizen of What Cou	ntry?		
	h with	al Di	303 Cedar Avenue			20877				USA			
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Ameri Black, White,			
30	s after	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:			Specify:			
2-003p	hour		15. Decedent's Ed	Ye ar or Dates:	16a. Dece	edent's Usual Occup	ation	_	16b.	Kind of Business/In	nite		
<u>ი</u>	hin 72 e. an "ne	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retired	during most of word d)	king	U	nited Sta	ates		
7	ygiene ygiene ier th	Completed	12	4	Pos	tal Serv				ostal Sei	cvice		
yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fredient Evantian must be notified at once.	Be	17. Father's Name (First, Middle, Last,)			18. Mother's Nam	_{lois Mar} Lois Mar					
Ž	should nd Me mark mark	٦	Corbin Bishop 19a. Informant's Name/Relationship	Type, Print)	19b. Mail	ing Address (Street					o Code)		
Z Z	nd 2 salth all 27 is 27 is or trau		Velma Lois Bishop	**	I	Cedar Ave					20877		
ore,	es 1 a of Hei		20a. Method of Disposition	20b. P	lace of Disp	osition (Name of ematory or other place	ce)	Date	20c.	Location - City or To	own, State		
Ĕ	Page ment lant: h		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) Men	mory G	ardens	4-23-	-		ountville	-		
Бакіто	Depart Mport Iny in	Ш	21. Signatu e f Funeral Service Lice	nsee		22. Name and Addre							
	20200		23a. Par 1. Enter the disease, or com	plications that caused the death						ountville	, TN 37617 Approximate		
	Physician		shock, or heart failure. List only the ediate Cause (Final	one cause on each line.							Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):									
	Examiner	_	Sequentially list conditions.	b. Peritoneal		inomatosi	3						
	tec Isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequ		esion							
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ρ 8/ρυ,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transition.	edical											
20	ertifica ing ph e as th	Med	IF FEMALE:										
Š Q	w requires that the death certif s been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of control of the	death 3	☐ Ectopic pregnand	с у		23d. Date of delivery Month Day Ye				
j	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	realii 5	Other (specify) _							
7.	s that ined b e deta	by Pr	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use contribute to the cause of death?				
ğ	equire en sig ould b		Crohn's Disease					1 🗆	Yes	2 ☐ No 3 ☐ Pro	No 3		
Records,	aw as t	Completed	<u>Ulcerative</u> coli	tis				24a. Was	psv	24b. Were autopsy findings available prior to completion of cause of			
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VItal	Physiclan: The law r this certificate has t ral director, page 2 si	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 N Inpatient 2 □	EB/Outpotic	ont 3 🗆 DOA Oth	26. Place of Dea			6 ☐ Other (Spec	····		
_	n 00	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	of 28c. Inju		28d. Describe			uy)		
SION	Attending r death. ector: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	n			Yes 2□No						
Š	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	ertification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, s fy)	treet, factory, office		28f. Location City or To	(Street wn, Sta	and Number or Rui ate)	ral Route Number,		
2	pital ours a leral C	ပ	29a. Certifier 1 ☑ Certifying P	hysician: To the best of my kno	wledge, dea	ath occurred at the t	me, date and place	e, and due to the	e cause	e(s) and manner as	stated.		
	e Hos n 24 h le Fun bletely	Medical		miner: On the basis of examina and manner stated.									
	To th within To th comp	ž	29b. Signature and title of certifier	10	2	29c. Licens	se number	2		Date signed (Month	, Day, Year)		
			MAG	Juran C.	eun-		16518		4	12909			
			30. Name and address of person who Simi Nourani Zer				Bethesd:	a. MD					
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture	Kel Kur,	Doenonde						
	Registr		ADD 2.9.200	9 Service po	19								

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		For Ame:	nd #5,p	erFh S	te 8f M	aryland /	Depa TT Cer	rtment o	f Healtl	h and M th	lental Hy	giene Reg. No. 2	2009	12822
		1. Decedent's Nam	ne (First, Middl	e, Last)					-		2. Date of De	ath		3. Time of Death
Physicia /Medic		Debac	an F	ean	a P	odd	ie				Month	Day	Zezo P	044 5AM
Examin		4a. Facility Name (4b. City, Tow	n, or Location	on of Death	71.	4c. Cc	ounty of Death	- L.L.
		JOHNE	HOPKINS	BAYVIFI	Umble	AL CER	vien		RALT	more	Ξ			
Funeral		5. Social Security N	Number + - Y + Y	6. Sex	7. Ag	e (In yrs. last	birthday)	If Under 1 Ye Months Da		der 24 Hrs.	8. Date of Birt (Month, Da	th y, Yea <u>r</u>)	9. Birthp	place (State or Foreign
Director		215-52-0		1□M 2	LI F	60	Yrs.		,,,		1/24	1949		gland
and		Usual Residence of 10a. State	10b. County			10c. City, To	own or Loc	eation					1	0d. Inside City Limits
f sho	ō	Mp	,											1 Yes 2 □ No
r 28a-f show	rec	10e. Street and Nu	ımber			Latt	timor	10f. Zip Cod	e		-	10a. Citizei	n of What Cour	ntrv?
23a or		1411 1	V. De	rkoa	Av.	0		212	_				ISA	
ter death	Funeral Director	11. Marital Status	v. De	12. Wa	as Decedent		13. V	Vas Decedent	of Hispanic	Origin? (Spe	ecify Yes or No		Race - Americ	
ral", or items 23a o		1 Never Mari	ried 2 Mari	ied 1 [med Forces?	No		Yes, specify (Rican, etc.)		Black, White,	
ral",	d by	3 Widowed	4 Divorced		res, Give ar or Dates:		'	□Yes 2 🗹	No Spec	хіу:		Sp	pecify: Bla	ic K
72 h 'natu	Completed	(Spe	15. Deceden	s Education	oleted)	1	(Give I	ent's Usual Ockind of work do	ne during n	nost of worki	ng I	16b. Kind	of Business/In	dustry
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iled v Hygie ther t nt, in		17. Father's Name	(Eiret Middle	Last) a	24		4	etail	19 M	other's Name	(First, Middle,	Maidan Su	C (N (V	
t be f	Be		ard	2/	WIC.	ทร			10. W	Tala.	/ (I II st, Wildule,	D D e	Fin	
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Experiment must be notified at	ို	19a Informant's N		hin /Time Pr	int) Dave	Shitel 1	19h Mailin	n Addrass (Su	eet and Nu	mber or Burs	al Route Number	er City or Ti	own State Zin	Codd 7 14 17
and 2 s ealth au n 27 is ner trau		DOS	iree		mas		141	IN.	Dec	Ker	Are	B	ulto 1	ng 215
s 1 au if Hea item othe		20a. Method of Dis	sposition			20b. Place	e of Dispos etery, crem	sition (Name o	nlana) e	9	Ate	20c. Locat	tion - City or To	own, State
perr it. Pages 1 and 2 should be filed within 72 hours Dep. rtment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any njury or other traumatic event, the Medical Exp			Cremation 5 ☐ Other Ø		al from State	Ma	etery, crem LIV	ed W	Mace)	4/2	2/09	Bi	Ho.	nd.
perrit. Depertmine Importal any nju			uneral Se vice		26	/	22	Name and Ad	dress of a	cility ////	eks W	itheo L	o Jan (lianel
S a la co		1/2	A14	ful	Il un		16	59 N	· 18	road	way	Brail	s hid.	21213
		23a. Part 1. Enter	ne lime or art failure. List	complication	s that caused	the death. D	Do not onte	er the mode of	dying, such	as cardiac o	or res atory a	rrest,		Approximate Interval Between
Physician		mmediate C / se disease or condition	(Final	only one out	ASC						/			Onset and Death
/Medical	1	resulting in death)		a		a consequen	ce of):							7 € 67 3
Examiner		Sequentially list co	onditions.	b										
sit ed	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying		Due to (or as a consequence of): Due to (or as a consequence of):									
and I-tran	хап	that initiated events resulting in death)	S	c										
icate be executed physician and the burial-transit	alE													
ficate phys the	dical			d										
eath certific attending p for use as	M/C	IF FEMALE:	at programt	23c. If y	es, outcome	of pregnancy	,					230	I. Date of delive	arv
death atte	ciar	23b. Was decedent pregnant in the past 12 menths? 1									250	Month	Day Year	
uires that the de signed by the d be detached f	Physician/Me	9 Unknown		9[Unknown			.,,,						
s that	by P	Part II. Other signi	ficant condition	ns contributi	ng to death b	ut not resultin	g in the un	derlying cause	given in Pa	ırt I.	23e. Did to	obacco use	contribute to the	ne cause of death?
w require been signations been signatured been	pa										1 🗆 ነ	′es 2□N	No 3□ Prot	pably 4 Unknown
aw requas been 2 should	Completed										24a. Was			psy findings available
The late has	E O								_			rmed?	death?	mpletion of cause of
sician: The law s certificate has b irector, page 2 sl	Be C	25. Was case refer examiner?	rred to medical						26. Pl	ace of Death	(Check only o		1 🗆 103	2 110
hysic his ce	2	1 Yes 2 □		Hospita	il: 1	ent 2 ER/	/Outpatient	3 2 DOA	Other: 4 🗆	Nursing Hor	me 5 🗌 Resid	dence 6	Other (Specif	(y)
ng P	ü.	27. Manner of Deat	th 5 ☐ Pendin		a. Date of Inju (Month, Da	ry 28t y, Year)	b. Time of Injury	28c. I	njury at Vork?	2	28d. Describe h	now injury o	ccurred	
tend leath. tor: / the f	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could r	ot bo					□Yes 2					
or At offer of Direction by	Certification:	4 ☐ Homicide	determ		building, et	ury - At home, c. <i>(Specify)</i>	, farm, stre	et, factory, offi	ce	2	28f. Location (S City or Tou	Street and N vn, State)	lumber or Rura	al Route Number,
pital burs a leral l		29a, Certifier	1 Certifyin	g Physician	: To the hest	of my knowled	dreah enh	accurred at th	e time date	and place	and due to the	cauca(c) ar	nd mannar ac c	tated
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)	2☐ Medical	Examiner: O	n the basis of nd manner sta	f examination	and/or inv	estigation, in r	ny opinion,	death occurr	ed at the time,	date and pla	ace, and due to	the cause(s)
To th within To th	₩	29b. Signature and	title of certifier					29c. Lic	ense numbe	ег		29d. Date s	igned (Month,	Day, Year)
5			Klu	ralle	Zen	MI	1	0	000	3684	′	APO	214 21	1 2009
(1)		30. Name and add			ed cause of d	eath (Item 23	a) (Type, F			- (, ,	21224
		EBWAN	ed Be	SMAN	ms.	494	OEK	RAENN	AVER	UE B	SHLTIM	on F	MD	21224
Stat		31. Date filed (Mon	nth, Day, Year)	2000	32. Registr	ar's Signatur	. 60	ares				/		
Registra	ar		APR 22	2003	Marie	La la	1	in						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS G890 4/22/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Walter Phillip. Boslev Jr. Physician 2009 3 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Upper Chesapeake Hospital Harford If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 □ F 54 Director 07/12/1954 MD 214-68-2296 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes ≱ No Director MD Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 USA 2209 Pulaski Highway Rm. 101 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed er than "natur , he Medical B 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaping Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other that any Injury or other traumatic event, The once. Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Phillip Bosley, Sr. Betty Whitcomb ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Bosley/Mother 1105 A Robin Hood Road High Point, NC 27262 Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr Beltsville, Maryland 2009 Chesapeake Crematory Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Marvland 21286 Approximate Interval Between Onset and Death 8717 Green Pastures Drive Baltimore Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 ☐ Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant anditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 robably 4 ☐ Unknown 1 ☐ Yes 2 □ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 1 Inpatient 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print) Matthew 4 . Union Ave. Harrede Grace: MD 21078 M.D. 407

State Registrar 31. Date filed (Month, Day, Year) APR 2 2 2009 09-03029 Bobby Joe Creamer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 12824 Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Year 2017 hrs April 15, 2009 **Medical Examiner** Creamer Joe Bobby c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year Age (In yrs. last birthday) 5. Social Security Number Foreign Country)Texas **Funeral** Days Hours Months 1949 Director 59 449-86-5494 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 x No or 28a-f show Coldspring s 23a or 28a-f show e notified at once. San Jacinto Texas Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 77331 171 Cedar Crest Lane 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status Funera If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married Never Married 1 X Yes Specify: White Yes 2 X No specify: If Yes, Give Year Divorced 1971 3 Widowed 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Safety Supervisor 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nell Humphrey Charles Creamer If item 27 is marked Be or other traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 171 Cedar Crest Lane Coldspring, TX 7733 B Brenda Creamer (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Baltimore, Removal from State X Burial 2 4-23-2009 Evergreen, TX Magnolia Cemetery Important: Other Specif ²² Name and Address of Facility Pace—Stancil Funeral Home 303 E. Crocket St., Cleveland, 21. Signature of Funeral Service Licensee nous 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death Medica Hypertensive Cardiovascular Disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Physician/Medical AMENDED UNPENDED this certificate has been signed by the attending physician director, page 2 should be detached for use as the burial 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I O. No 3 Probably 4 V Unknown Yes 2 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, prior to completion of cause of autopsy performed? death? Yes 2 V No Yes 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ Residence 6 examiner? Nursing Home 5 Hospital: 1 / Inpatient DOA this 1 🗸 Yes ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury funeral 28a. Date of Injury (Month, Day, Year 27 Manner of Death After Certification: Yes 2 1 V Natural Pending Funeral Director: stely filled in by the 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 16, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) park State

Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 20<u>09</u> **Physician** 7:18 PMApril 16, W. Claassen, Sr. E1mer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Franklin Woods Center Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days **X**M 2□ F Yrs. 14, 1914 Maryland Director 94 217-01-0687 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 TyYes 2 □ No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 4207 Kenwood Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad 10 Weigh Master 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Claassen ဥ Diderich Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21784 5686 French Avenue Sykesville Gary Claassen/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. 04/20/2009 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Miller-Dippel Funeral Home,
6415 Belair Road Baltimore 21206 23a. Part1. Enter the disease. In complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive pars /Medical Due to (or as consequence of): **Examiner** works ar Sequentially list conditions Due to or as a cons uence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760. as IF FEMALE: use If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe history D 1 ☐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Franklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 04-20-2009 800 A Phyllis Lee Delosier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 204 C Fairwood Rd Bel Air 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 03Months Day 9'38 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 71 MD Director 219-38-0835 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 204 C Fairwood Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced natura!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Engineering Co. is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Lee Delosier Catherine Muma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is Injury or other trau 1706 Quenon Ct Jarrettsville, MD 21084 Rachel Morgan (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ဳ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 04-23, 2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Duran 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery il or Attending Physician: The law requires that the death a after death.

Director: After this certificate has been signed by the attent 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Records, Vital Division of

within 24 hours a To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

Registrar's Signatu

oleted cause of death (Item 23a) (Type, Print)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12/4 Month Physician 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1314 Wood bounn Aye TIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 190-38-3119 1 M 2 F Yrs Director 100 MAKCH 30, 1909 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examinar must be notified at 1 Yes 2 No Director MD, BAHTIMORE 10g. Citizen of What Country? 10e. Street and Number Are 4.5.A Funeral 1214 Woodburne 2/239 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 Too If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: Specify: BALK þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hone Kreeping Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None Domestic 10 geAde Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HEAR Toliver ဥ HOWAKO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mportant: If item 27 Ave BAIT more MD. 21239 Woodburne Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ing Mem. PR 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
BETTS FURCES
1129 N. CAR 21. Signature of Funeral Service Licensee Mone any AROLI 12 ST, BATTIMORE ruced ma) Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner thero er Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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amend #1 Pex Phy G890 4/21/09 JH

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of IN	taryland		rtificate of i	ieaith and N Death		giene Reg. No. 2 / /	19 12828
	Physici /Medic		Decedent's Name (First, Middle, Last) AHGUST BARLETT DTXON	August	Bar	tlett Dix	con	2. Date of De Month	ath Day Ye	
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number		tal		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo				,1020	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examir or must be rediffed at	al Director	Maryland Baltimore 10e. Street and Number 7011 Ridge Rd.			Baltimore 10f. Zip Code	21237		10g. Citizen of Wha	
0036	ours after dea ral", or items Examiner m	by Funeral	11. Marital Status 1 Never Married XXX Married 3 Widowed 4 Divorced 12. Was Deceder Armed Forces 1 Yes, Give Year or Dates	6?] No		Was Decedent of H f Yes, specify Cuba 1 □Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
altimore, Maryland 21215-0036	filed within 72 ho Hygiene. ither than "natu ant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) B yrs. College (1-40	r 5+)	(Give life. i	dent's Usual Occup kind of work done o DO NOT use retired Motor Di	during most of work d)	ing	16b. Kind of Busin	•
Aut		To Be C	17. Father's Name (First, Middle, Last) Warren Scott Dixon 10. Interment's Name/Politicashin (Tipe, Brief)	Maiden Surname) 1S	to Tin Code)					
X VON re, Ma	s 1 and 2 sh if Health and item 27 is n other traun		19a. Informant's Name/Relationship (Type. Print) Rosslee Dixon (Wife) 20a. Method of Disposition	20b. Pli	7011		d. Baltim		er, City or Town, Staryland 2 20c. Location - City	1237
Baltimo	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		1 Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify) 21. Separatury of Funeral Service □ Cremsee	e	rdens	of Faith 2. Name and Addre	↓ 4 ≥ 20 ss of Facility	-2009	Baltimor 7401 Bela	ir Rd.
	Physician		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	ed the death.	Do not ent		Funeral Hong, such as cardiac			Approximate Interval Between Onset and Death
68760, 64	Medicale be executed a physician and burial-transit as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate eause. Enter unsaring 5 Cause (Disease or injury that inlitated events	as a conseque	ence of):					
Вох	at the death certific by the attending prached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcon 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 Fetal	death 3 [Ectopic pregnanc Other (specify)	у		23d. Date o Month	f delivery Day Year
ords, P	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death Hypertension Contribution	but not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did t		te to the cause of death?
tal Rec	sician: The law certificate has b rector, page 2 sh	e Completed by	25. Was case referred to medical				OC Plans of Poot	1 □ Yes	psy prio ormed? dea 2 √2 No 1 □	e autopsy findings available r to completion of cause of th? Yes 2 □No
Division of Vital Records, P.O.	n g Phys fter this neral di	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inper 27. Manner of Death 1 Natural 5 Pending investigation investigation	Day, Year)	28b. Time o Injury	28c. Injur Wor	4 □ Nursing Ho	me 5 Resi 28d. Describe	dence 6 Other (how injury occurred	Specify) or Rural Route Number,
Ö	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer	29a. Certifier (Check only (Ch	st of my know	vledge, deat	h occurred at the ti	me, date and place	and due to the	cause(s) and mann	er as stated. due to the cause(s)
	To the within 2 To the complet	Med	one) and manner 29b. Signature and title of certifier.	stated.		29c, Licens	e number		29d. Date signed (A	Month, Day, Year)
	Sta Registr		30. Name and address of person who completed cause of the complete cause of the ca	death (Item	Fra	Print) NKIN	Sq. Drive	Bai	timare	md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Certificate of Death **Physician** /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1 - State Registrar			Cer	tificate of	Death)		Reg. N	lo. 2 ()	09	12	829
1. Decedent's Name (First, Midd	lle, Last)						2. Date of D		lav	Voor	3. Time of	Death
WENDELL	NUSE	AUM	DUFF				Month APRIL		2009	Year	11:30) A M
4a. Facility Name (If not institution		mber)		4b. City, Town, o FREDER				4	c. County FREDI		1	<u> </u>
5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of B	irth Dav. Yea	r)	9. Birthp	olace (State on try) yland	r Foreign
577-28-6010	1 X M 2□ F	85	Yrs.	Working Duy's	Tiodio		8. Date of B (Month, D Dec.	11,	1923	Mar	yland	
Usual Residence of Decedent 10a. State 10b. County	,	100 Cit	y, Town or Lo	nation							0d. Inside Cit	ty Limite
	rederick	100.01		Adamstown	า						1 ☐ Yes	1
10e. Street and Number				10f. Zip Code				10g. C	Citizen of V		ntry?	
3113 Chartwe	ll Crescen	t Lane		217	710				U.	S.A.		
11. Marital Status	12. Was Dece Armed Fo	dent Ever in U. rces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic O an, Mexica	rigin? (Sp ın, Puerto	ecify Yes or N Rican, etc.)	lo-		e - Americ	can Indian, etc.	
1 Never Married 2 Ma	rried 1 XYes If Yes, Giv	2 □ No /e ates: 1942-	16	I∐Yes 2⊠No	Specify	<i>'</i> :			Specify	Whi	ita	
3 Widowed 4 Divorce		ates: 1942-						7		******		
15. Decede (Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done	durina mo:	st of work	ing	16b.	Kind of Bu	isiness/In	dustry	
Elementary/Secondary (0-12)	College (1	-4or 5+)		00 NOT use retired wner/ope	•				eior	n sho	n	
17. Father's Name (First, Middle	Last)			wher / Ope.			e (First, Middle	e. Maide			Р	
Rockward Nusba					10. 141011		rl Star		,,, 00,,,,	,0)		
			405 14-75-	. Add /Otro-1	A \$ 1					04-4- 7'-	. 0 . 4 - \	
19a. Informant's Name/Relation Edith Duff/ wi	, , , , ,		3113	g Address (Street Chartwel	l Cre	scen	t Lane,	, Ad	amsto	wn,	MD 217	10
20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 D Removal from	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	[Date	20c.	Location -	City or To	wn, State	
4 □ Donation 5 □ Other (All	Count	y Cremat:	ion	4/21	/2009	Sy	kesvi	lle,	MD	
21. Signature of Juneral Service	Lionie Lionie	Sler		. Name and Addre			tzler E New Win				76	
23a. Part 1. Enter the disease, c shock, or heart failure. Lis immediate Cause (Final disease or condition	t only one cause on e	aused the death ach line.	n. Do not ente	er the mode of dyi					•		Approximate Interval Betwoonset and D	ween
resulting in death)	Due to	or as a consequence	uence of): Failur	e							DAYS	5
Sequentially list conditions, if any scale, to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6 Ca	or as a consequence or as a consequence of the cons	rcy f	Artery	Di	5ea	કેર				Years	5
	d											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	come of pregna pirth 2□ Feta nant at time of d own	Ideath 3	Ectopic pregnanc Other (specify)	y			9		te of delive		/ear
Part II. Other significant condit	ions contributing to de	eath but not resu	ulting in the ur	nderlying cause giv	en in Part	I.			use cont		he cause of de	eath? Inknown
							24a. Wa auto peri 1 ∐Yes	opsy formed?		Were auto prior to co death? 1 □Yes	psy findings a mpletion of ca 2 No	available ause of
25. Was case referred to medica examiner?						e of Deat	h (Check only					
1 Yes 2√2 No			ER/Outpatien	t 3 □ DOA Oth	er: 4 🗆 N	lursing Ho	me 5 🗆 Res	sidence	6 □Oth	er (Specil	<i>fy)</i>	
27. Manner of Death 1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest	28a. Date (Moning igation	of Injury th, Day, Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊑		28d. Describe	how inj	ury occurr	ed		
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place buildi	of Injury - At hong, etc. <i>(Specif</i>)	ome, farm, stre	eet, factory, office			28f. Location City or To	(Street a	and Numb ite)	er or Rura	al Route Numi	ber,
29a. Certifier 1 Certifyl (Check only one) 2 Medica	ing Physician: To the I Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or in	n occurred at the ti vestigation, in my o	me, date a opinion, de	and place, eath occur	and due to th	e cause e, date a	(s) and mand mand place,	anner as s and due to	stated. the cause(s))
29b. Signature and title of certific		·		29c. Licens	e number						Day, Year)	0
30. Name and address of person	Fauzi who completed caus	Kizvi	_		2180			Ap	pril	18 /	200	7
400 West	7th S	freet	Pr	Print) Ellert C	K_							
31. Date filed (Month, Day, Year	2 2009	egistrar's Signa	d.	arke								

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 17 2009 Elizabeth Mary Dovle 8:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford County Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours 1 □ M 2 □ **V**F 219 16 7725 84 February 6°1925 Baltimore, Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any Injury or other traumatic event, the Medical Examiner must be notifled at Maryland Harford Harford County Director 1 □Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Barnette Lane Apt. 211 21001 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X Xo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XXNo þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1/Ar 5+) Elementary/Secondary (0-12) Homemaker Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 Is marked o William Lessner Mary Weisterhoff ျှ 19a. Informant's Name/Relationship (Type, Print)
J. Lynn Ward (Daugnter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 660 Kildonan Ct. Bel Air, Md. 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. April 20 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.

Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 ☒ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24807 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Vital 2 X No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Sinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Division or P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 00068014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVRE de GRACE, MO. 21078 901 S. UNION Dener 38 Pegisty's Signal Registrar

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09-03082

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physician/ Examine	'		hy Edwar						April 17,	2009	. County of De	
	4	a. Facility Name (in	f not institution, give	e street and number)			City, Town, or I	Location of	Death		Baltimore C	
	H	6511 Beech	wood Road				Baltimore	I K I Indan	24Hm le Date of			Birthplace (State or
Funeral	5	Social Security N	lumber 6. Se	7. Age	(In yrs. last b	oirthday)	If Under 1 Year Months Days		Min.		Fo	reign Country) MD
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show, injury or other traumatic event, the Medical Examiner must be notified at once.	-1	Mourice I Dix Father				3216	216 Pinecrest Court, Abingdon, MD 2				city or Town, State	
e, N I and Health item		20a. Method of Di	sposition	Demousl from S		ace of Disposi ematory or oth	tion (Name of o er place)	emetery,		1		
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Baltimore, permit. Pages I an Department of Hes Important: If iten injury or other tr	- 1	21. Signature of F	uneral Service Lic	ensee			ame and Addre					stown Road
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2009 April **Physician** 19, 1:30 a. M Alice Davis Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birth (Month, Day, Yea A110. 16. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign . 19<u>16</u> **Funeral** Days 1 □ M 2 X F Months Hours New Hampshire 92 003-10-2738 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural" or was any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDGaithersburg Montgomery 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 United States 403 Russell Ave. #316 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 No 1Yes. Give WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify ۵ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Physical Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel F. Davis Nina May Ball ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natt Davis (nephew) 1425 Montcliff Dr. Cumming, Georgia 30041 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aprilate 22, 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Ser. M00982 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate he

attending physician and for use as the burial-transit

cate has been signed by the page 2 should be detached

funeral director,

filled in by the

29a. Certifier

dich

(Check only one)

29b. Signature and title of certifier

completely

DHMH 17 Rev 1/2001

Registrar

Leinbera Ssell 31. Date filed (Month, Day, Year) 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pegatrar's Signature

Juno

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#17perFH. G890.4/22/09 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margaret Month O4 **Physician** Dudle 18 2009 10:55 AM /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Examiner Of Pikesville Baltimole Pikesville 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗷 F Days Hours Min Months 03-14-1928 Yrs Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10d. Inside City Limits show 10c. City, Town or Location injury or other traumatic event, the Medical Eval; then taust be notified at Battimoee 1 Yes 2 No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21213 Washington St. Funeral items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married o, 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black 2 'natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, I'm Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Catonsville, MD 21228 oudley (husbard) 1015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Carlison Forest 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 28-09 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vougno Green Function Services e of Funeral Service License Baltimore Not'l Pike (lene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Leavs **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ZNo 1 ☐Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 710el 25 Mani 31. Date filed (Month, Day, Year) APR 2 2 2009 Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28a,b,c per me, 2890,04/22/09dhb
Reg. No. 1 - For State Registrar Amend Items Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** David В. Dawson 5:00 A^M April 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Co. 7003 River Drive Road Edgemere 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 1 1 √ M 2 □ F 220-68-6134 51 Yrs Maryland Director 1957 May 1, Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, it a Medical Examiner must be notified at Edgemere 1 □Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21219 7003 River Drive Road 23a United States Funeral death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 27 Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 No Specify: \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within than ' Elementary/Secondary (0-12) College (1-4or 5+) Frame Assembler Manufacturing 12 should be filed with and Mental Hygier 7 is marked other the 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joyce G. Vetters Joseph J. Dawson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra 7003 River Drive Road Edgemere, Maryland 21219 Mrs. Rebecca L. Dawson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/14/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland art1. Enter the disease, complications that caus shock, or heart failure. List only one cause or each emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lo licted disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a someoquenes of): requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2**⊠**No Division of Vital 1 ☐Yes 2 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury
(Month. Day, Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation Found: A_M death. 1 □Yes 2 X No suicide Gunshot to head 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 04/11/2009 filled in by the Unknown 3 Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 7003 Rue Dr Rd determined Edgemen MG. 21219 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H:1) CT. Lyther ville

Registrar

State

31. Date filed (Month,

Qay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM WOODROW ESSIG APRIL 2009 6:10A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town, or Location of Death Rock Spring Village Forest Hill Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Days Months Hours Min. 1 ☑ M 2 ☐ F 232-03-2002 91 Mar. 21,1918 V W. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Kingsville 1 Yes 2 XX Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Petem Rd. 21087 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. Specify: White WW 11 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs. Machinist/Tool & Diemaker Middlestadt Mach.Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otto Essiq Elenor Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 963 Gainesborough Ct. Belair, Md. 21014 Michael Essig (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4-25-2009 Baltimore, Md. 22. Name and Address of Facility
Lassahn Funeral Home Signature of Funeral Service Licensee Methou 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Fo not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an

Physician /Medical Examiner

cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar

this certificate has

completely filled in by the funeral director,

after death.

To the Hospital within 24 hours a To the Funeral C

ical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

Examiner

Funeral

Director

28a-f shov

Director

Funeral

Completed by

Be

2

821

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite

Maryland 21215-0036

Baltimore,

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manper of Death 5 Pending investigation 1 Natural

2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury Date of Injury (Month, Day, Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \(\triangle \) Nursing Home \(\frac{5 \triangle A}{2} \) esidence \(6 \triangle A \) Other \((Specify \) iving 28d. Describe how injury occurred

autopsy performe 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MD

2009

Assited

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 2 2 2009

NORTH 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** Helen Miriam Earley 18, April 10:25 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Year) 1 □ M 2 X F Months Days Hours Min. 83 207-14-1405 Director 2/1926 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural" or items 23a or 28a-f show other traumatic event, it is Medical Examination must be notified at MD Anne Arundel Edgewater 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 87 Stewart Dr. Apt 402 21037 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Adamaitis Patricia unk Tylenis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If item 27 is any Injury or other trau once. Jim Earley/Son 975 Roundhouse Ct. West Chester, PA 19380 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Chesapeake Crem. 4/21/2009 Beltsville, MD 21. Signature of Funeral Service Licensee 32. Name and Address of Facility CAFA/Stephen D Lohrmann P.A. Green Pastures Dr, Towson, MD, 21286 J 8717 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Clease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) buriel-transi attending physician and for use as the buriel-trar Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 K No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t page 2 s 24a. Was an autop: After this certificate funeral director, pag Vital 2X No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \textbf{X}\) Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 2 ☐ Accident 5 Pending investigation death. filled in by the f 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a

To the Funerel I

completely filled to the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examiner Nurse Practitioner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

2009

APRIL 18,

EARLEY

HELEN

ORIGINAL

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:53P 19,2009 Richard Aldridge Fryer April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4248 Darleigh Rd. Balto Nottingham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23,1932 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 14 M 2 □ F Hours Min. Months Days Pennsylvania **Director** 206-28-1412 76 Usual Residence of Decedent 10d. Inside City Limits show 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Exempter must be notified at Director 1 ☐ Yes 2 ☐ No Nottingham Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 21236 4248 Darleigh Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes ŽŪNo Specify White þ Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Engineering Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul A. Fryer Marion L. Ayer မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 <u>Joyce W. Fryer</u> Spouse <u>4248 Darleigh Rd.</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-21-2009 Bayview Balto. City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a shift line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or all The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No o the detached 9 Unknown 9 Unknown ئە ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? has page 2 certificate 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DM0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of this 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only the

State Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)_

Dr. Ali Sanali

ho completed cause of death (Item 23a) (Type, Print)

6730 Holabird Ave. Dundalk, Md. 21222

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 19, **Physician** 2009 4:30 A M ROBERT B. FUNK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MAPLES OF TOWSON TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN, 3, JAN, 3, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) 1 🖳 M 2 🗆 F 219-01-9249 84 Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Example of interpretation of the control of the contro 1 Yes 2 No Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5918 WALTHER AVE 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Musical Executa 1 Never Married 2 Married 3altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🗷 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9TH SUPERVISOR STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT FUNK MARY BOULDIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHARLES FUNK-BROTHER 15235 O'NEAL RD APT 132 GULFPORT, MS 39503 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK 4/22/09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licensee 6415 BELAIR RD BALTIMORE, MD 21206 Approximate Interval Between Onset and Death 23a.P 11. En the disease short, or heart failure. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Lunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 MOther (Specify) ALF 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

State Registrar (Check only one)

29b. Signature and title of certifier

Medical

31. Date filed (Month, Day, Year)

1 KC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

100014

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 19, Day 2009 Year NANCY FREDERICK 10:25A M Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth FEB 21 1968 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months MARYLAND 214-94-3657 1 □ M 2 🗓 F 41 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 VALLEY MEADOW CIRCLE B-1 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE AGENT INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MICHAEL LICHTIG JUDITH Ε. DALBERG В. 19b. Mailing Address (Street and Number of Rural Route Number City of Town, State, Zip Gode) 21136 TREVOR FREDERICK/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI CONG. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 04/21/2009 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Self 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUMITATIC 14 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to intrinsinate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for no a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) MSPW 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show

nd Mental Hygiene. marked other than

nt of Health and Ments:
If item 27 is marked
or other traumatic ev

permit. Pages 1 and 2 a Department of Health an Important; If item 27 is any Injury or other trau

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Baltimore,

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Funeral

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filed within 72 hours after death with the Maryland

Examiner Physician/Medical

requires that the death certificate be executed attending physician as the the director, page 2 should be law I has • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica

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Medical Certification: To

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Records,

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IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknow

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be determined

6701 N. Charles ST TONSON MD Z120

State Registrar 31. Date filed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da 04-17-2009 Mary A. Goguen 1244 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-07-1960 Birthplace (State or Foreign Country) Min. Months Days Hours 021-52-7808 49 Canada Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☑ No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Vanguard Way Apt I USA 21014 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchase Order Coordinator Home Builders Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Martin Della Cormier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph C. Goguen (Husband) 1123 Vanguard Way Apt I Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 04-20-2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DOME 12 hRS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Effici Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chaunic KIDNEY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

s certificate has b irector, page 2 s

Hospital or Attending Physiclan: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p

in 24 house the Funeral Director of the filled in by

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any fujury or other traumatic event, it is gone.

Physician

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Completed

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Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at

with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore

ogiven May M80039372/ Division of Vital Records, P.O. Box 6876

744

attending physician and for use as the burial-trar

Physician/Medical ģ Completed Be ၀

Certification:

Medical

29a. Certifier

(Check only

1 Yes 2 No 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certific

29c. License number 29d. Date signed (Month, Day, Year) 10056296

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chesapeake Dr. Bel Lir, M.D 21014 .500 Upper ason 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** P^{M} Freddie Lynn Goudy Sr. 2009 8:31 April 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Elkton** Cecil Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/5/1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Vear Months 1**X** M 2 □ F 214-42-1925 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County t be notified at 1X7Yes 2 □ No Director MD Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 150 E. Main Street #205 21921 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the M Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygient Important: If item 27 is arked other than any injury or other trau and ince. 10 Production Worker Fireworks 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Friend Jones Goudy Junia Veda Jeffrey ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Goudy Sr./ Son Leeds Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4/20/2009 Hanover, Maryland 4X Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final muce **Physician** 50 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-tra Due to (or as a consequence of): physician a the burial Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) Ö the 9 Unknown signed by t ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has birector, page 2 s Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No thours after death.

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ely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 2028 P M KYRESE CHRISTOPHER APM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 220-83-7914 Yrs MARYLAND MARCH 11, 2009 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a 1 Yes 2 □ No Director BALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? LAURET 2636 Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 2 X No 1 ¥ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🕱 No þ Specify: BLACK 3 Widowed 4 Divorced marked other than "natural", matic event, the MedIcal Exa Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be GARY CHRISTOPHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau (MOTHER) 2636 LAURETTA AVE., BALTIMORE, MD 21225 KEYITA OPHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MCM. PARK 04/24/2009 BALTIMORE, MARYLAND 22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME

3140 N. FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses retrich N.h ulliamo 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** Congenital Heart 6 weeks disease or condition resulting in death) /Medical Due' (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a conse uence of or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kenal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Stroke 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 ☐ Yes မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the fune 5 Pending investigation 1 Natural **Injury** 1 Tes 2 🗌 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of pe

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April 20, 2009

600 North Wolfe St, Baltimore, MD, 21287

MID

LUCKMAN

son who completed cause of death (Item 23a) (Type, Print)

registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Godin. Sr. 37 AM Robert 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 ₩ M 2 □ F Months Days Hours Min. May 10° 91 046-07-2402 Connecticut Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Director Baltimore 1 ☐ Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8617 Richmond Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 tyles 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 K No Specify. <u>}</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Petty Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Godin Ida Chartrand Louis Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce E. Godin (Son) 8617 Richmond Ave., Baltimore, MD 21234 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bairimore at Cremare or y 4/22/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland @ Loudon Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a, Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Gastine Carcenoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner with U liver if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2/No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division the Hospital or Attending 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deep Sharma

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		_	Registrar	t Middle Lee	4)		Cei	rtificate	e or D	eain		Date of De	Reg. No.	200	7	3. Time of	Dooth U
	Physici /Medio		1. Decedent's Name (First Adella	Gas	unas							Month 04	Day 18	U	9	12:2	7AM
	Examir	ner	4a. Facility Name (If not in		1 1	ner)		4b City,	Town, or L	ocation of	Death		4c.	County of D	eath		
			5. Social Security Number	martin		Age (In yrs.	last hirthday)	If Under	Year	If Under 24	4 Hrs. I a	Date of Bir	th	n	A Birthplac	e (State (or Foreign
	Funeral Director		218 14 49		M 2 □ F ′	84	Yrs.	Months	Days		Min.	Date of Bir (Month, Da eb. 05	y, Year)	25	Country	ID	or r oreign
			Usual Residence of Dece										,				
	rylan show	_	10a. State 10b.	County		10c. Cit	y, Town or Lo	cation							10d.	Inside Ci	-
	8a-f s	ecto	MD	n/a	<u>-</u>			Balti		Э							2 □ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Wedfan Evantize must be notified at	Funeral Director	10e. Street and Number	in 7	_			10f. Zip	2121	10			-	zen of What	Country	?	
	sath v	era	616 McKew	III AV	12. Was Deced	ant Ever in II	S 12	Was Deced			in? (Specifi	Ves or No		SA 14. Race - A	merican	Indian	
	ter de iner	표	11. Marital Status 1 Never Married 2	☐ Married	Armed Forc	es?	1	Was Deced If Yes, spec		, Mexican,	Puerto Ric	an, etc.)	,	Black, W			
036	urs af	ē	3 ☐ Widowed 4 ☐ □		1 ∐Yes 2 If Yes, Give Year or Dat	es:		1∐Yes 2	X No	Specify:				Specify: V	hit	.e	
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7	within 7 ene. than "I	ם	Elementary/Secondary		College (1-4	or 5+)	life.	DO NOT us	e retired)	mg moor c	or working						
	filed w Hygier other th		12th 17. Father's Name (First,	Middle Leet			ur	empl			a Nama (E	irst, Middle	Maidan	/a			
anc	l be fi	B	unknown	ivildule, Last)					'	unkr		irsi, iviladile	, ivialuell	Surriame)			
Maryland	should be filed and Mental Hygi and Mental Hygi Is marked other aumatic event, I	٩	19a. Informant's Name/R	elationshin /7	vne Print)		19h Mailir	na Address	(Street ar			oute Numb	er City o	r Town, Stat	e Zin Co	nde)	
≥	and 2 s ealth ar n 27 Is ner trau		Patricia			eProv		•						imore			
ē,	s 1 and 3 if Health Item 27 other tr		20a. Method of Dispositio	ก		200. P	Place of Dispo				Date			cation - City			
5	Pages 'nent of I		1 ☐ Burial 2 ☐ Cre 4 ☐ Bonation 5 ☐ C	mation 3 🗆 Other <i>(Specify</i>	Removal from St	are /i/	en Mo				cv Ar	oril	21.	2009	Bal	to - N	4d
Baltimore,	permit. Page Department of Important: If any Injury or once.		21 Signature of Funeral			/	C ²	2. Name an	d Address	of Facility	1000	Func	<u> </u>	Home	Dui	0071	10.
œ	8 3 2 6		Demai	Une	011	mis	1 /	112 E	ם. L. Pr	cesto	aggs on St	rune		nome • Md		213	
			23a. Part 1. Enter the dis	ease, or comp	olications that cau	sed the e	Do not ent	er the mod	e of dying,	, such as ca	ardiac or re	spiratory a	rrest,	0 / 1 100 •	Ap In	pproximat terval Bet	ween
	Physician		Immediate Cause (Final disease or condition		atria	1 Gr	dall	~							0	nset and I	Death / S
مرزور	/Medical		resulting in death)		Due to (or	as a consequ	uence of):									-	
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	ted sit	Examiner	Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events	te 🗶	Due to (or	as a consequ	uence of):									,	
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9	death certificate be executed e attending physician and d for use as the burial-transit																
Вох	th cer endir	N/	IF FEMALE: 23b. Was decedent preg	pernt	23c. If yes, outco	me of pregna th 2 🗆 Feta		☐ Ectopic p	regnancy				1 2	23d. Date of			
	ed for	Physician/Med	In the past 12 month 1 ☐ Yes 2 ☐ No	ns?		nt at time of c		Other (sp						Month	Da	ay `	Year
P.0	s that the de ined by the a detached	Ph	9 Unknown				ulain m in alon			in Dani I		OSo Did i	ahaasa u	se contribute	a to the	nough of a	dooth?
S,	The law requires that the ate has been signed by th page 2 should be detache	Ş.	Part II. Other significant		A Common to dea	An		nuenying ca	ause given	imraiti.			Yes 2[ly 4 🔀	
Š	w requires s been sign should be	Completed	- werter tha) 042	<u> </u>	,					_						
æ	has l	ф										24a. Was auto		24b. Were prior death	to compi	findings letion of c	available ause of
Vital Records,	lclan: The l certificate ha ector, page		05 Man ann arfamad to									1 □Yes	2 🖭 No		es 2	□No	
₹	Physician: r this certificaral director, p	Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No	F	Hospital:	patient 2 🗆	EB/Outpation	y 2□ DC	Othor			heck only o		Other (5)(4.)		
ō		Ĕ	27. Manne of Death		28a. Date of	Injury	28b. Time o		8c. Injury	at		. Describe			респу)		
ion	ath. T: Aft	ațio	1 √ atural 5 ☐ 2 ☐ Accident	Pending investigation		Day, Year)	Injury	М	Work? 1 □ Ye	es 2∐No	0						
Division	• Attendi er death. • ector: A by the fu	ijij	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	Zoe. Flace 0	Injury - At ho	ome, farm, str	eet, factory	, office		28f.	Location (d Number or	Rural R	oute Num	nber,
Ö	tal or rs after all Districtions and Dis	Certification: To															
\	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical			ysician: To the bas ilner: On the bas and manne	is of examina											s)
1	To the within 2 To the сотре	Me	29b. Signature and title o	fcertifier				290	. License	number			29d. Dat	e signed (M	onth, Daj	y, Year)	
			()					R	ES-	000			4.15	8-09			
			30 Name and address of	person who	completed cause	of death (Iten	n 23a) (Type,	Print)	-/ A	, / .	-1	0	/	DI	10	10	20
			COUTT	123	KON	gistrar's Signa	/V.	05	160	100	Ch	KAY	211	5110	\propto	10	27
	Sta Registi		31. Date filed (Month, Da	2 2009	Genes	Journal's Signa	Land	4									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hyg

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eg. No.	U	U	D	1	4	O	in h	

Physician	
/Medical	
Examiner	

Funeral Director

items 23a or 28a-f show traumatic event, the Mydical Examiner is ust be notified at Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records,

reral Director: A within 24 hours a

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 04-19-2009 630 P Ernest HoskinsSr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1322 Grafton Shop Rd Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-08-1933 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days t**▼** M 2□ F Hours Yrs. 75 213-30-4942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2X No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1322 Grafton Shop Rd 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Radio Engineer WRAT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Green Hoskins Marie Messer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. Nellie Hoskins (Wife) 1322 Grafton Shop Rd Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gar. 04-22-2009 Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preu monia 2 weeks disease or condition resulting in death) Chronic Obstructive Pulmonary Discase 7 YEATS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Nun-Insulin Dependent Diabetes Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🗹 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Finendum 20, 2009 D39763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2012 Tollapte Kd. Ste 102 Bel Hr, MD 21015 Lee TAnnenbaum, 31. Date filed (Month, Bay, Year) ___ . .. State ion S. park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 2009 JORIE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SEASONS 105PICE RANDALLSTOWN Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 🛣 F 66 217-40-2661 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10b, County 10c. City, Town or Location 1 ☐ Yes 2 No DPNN MARYLAND BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3833 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: BLACK 3 XWidowed 4 □ Divorced

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be rediffed at

/Medical

Physician /Medical Examiner

Department of Heal Important: If item 2 any injury or other once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Be Completed by Physician/Medical Examiner

Medical Certification: To

15. Decedent's Education (Specify only highest grade completed)	Give kind of work don	e during most of working		Kind of Business/	industry
Elementary/Secondary (0-12) College (1-4or 5+)	CDUNSE.		4	IFE II	NC.
17. Father's Name (First, Middle, Last)	1 00010	18. Mother's Name (First, Middle, Maide	en Sumame)	
RAY MOSLE	=4	HENRIET	TTA	CLEVE	LAND
19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Stree	et and Number or Rural	Route Number, City	or Town, State, 2	Zip Code)
WILLIAM RAY MOSLEY (NEPHELL	2419 MOLTE	EN WAY,U			7D21244
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place) 16 MEM. PAI		/	Location - City or	Town, State ", MARYLAND
21. Signature of Funeral Service Licensee	22. Name and Add	Iress of Facility FULTON AVE	JR. FLE., BALTIM	NERAL MORE, M	HOME DZIZIT
23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	th. Do not enter the mode of d	ying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Due to (or as a consec					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	juence of):				
resulting in death) Last Due to (or as a consected d.	juence of):				
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Ectopic pregna			23d. Date of del Month	ivery Day Year
Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause ç	given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
It at Stroke			1 ☐ Yes	2 1 No 3 □ Pr	robably 4 ☐ Unknown
In ap Digheles Melliler	o		24a. Was an	24b. Were au	itopsy findings available
1h of Tuberculosis			autopsy performed?	death?	completion of cause of 2 □ No
25. Was case referred to medical		26. Place of Death	(Check only one)		
examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 □ DOA	other: 4 \sum Nursing Hom	e 5 🗆 Residence	6 Other (Spe	soms Hospice
27. Manner of Death 1		jury at 28 ork? □Yes 2 □No	3d. Describe how in	ury occurred	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Spec.	nome, farm, street, factory, office	e 28	3f. Location (Street City or Town, Sta	and Number or Ru te)	ural Route Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.					
29b. Signature and title of certifier	29c. Lice	nse number	29d. [Date signed (Mont	h, Day, Year)
I du i Oilila Buston	H	+5931	A	Pri) 17	TU 2009

DHMH 17 Rev 1/2001

State Registrar 2835

32. Registrar's Signature

Smith Avenus Svite 203 Batt I more MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ton

Debble

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 12:00 P M 2009 April Marvin Houck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glade Valley Nursing & Rehab. Center Walkersville Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 X M 2 □ F 8, Maryland **Director** 217-12-1692 Dec. 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Walkersville Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 24 Main St. 21793 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🕱 No Specify: If Yes. Give \$ 3 X Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 tax auditor state government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ira George Houck Beulah Rebecca Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquelyn DeWitt/ daughter 8914 Mountainberry Circle Frederick, MD 21702 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Parial 2 ☐ Cremation 3 ☐ Removal from State Glade Cemetery 4/23/2009 Walkersville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0/00 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ∐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ in by the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ∐Yes 2 ∐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D0031058

09-031	00	
Calvin	C	Haves

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aivin C. nayes	1- For State Certificate of Death Reg. No.	84
Physician/	Recustrat 1 Decedent's Name (First Middle, Last) 2 Date of Death 3. Time of Death	
ledical Examine	Calvin C. Hayes Vear April 18, 2009 4a. Facility Name (if not institution, give street and number) Vear April 18, 2009 4b. City, Town, or Location of Death 4c. County of Death	_
	Johns Hopkins Hospital Baltimore n/a	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	imits
*	MD n/a Baltimore 1 x Yes 2	No
ceath with the Maryland or items 23a or 28a-f sho must be notified at once.		
5-0036 ed within 72 hours after tygiene. the Medical Examiner Completed by	160 Dates: AT IIIV	ing
within giene. her that her that	2 yrs Supervisor Reliffing The. 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica		
D 21 thould bend Mer is mar atic ever	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' injury or other traumatic event, the Medical To Be Complet	Magdalene Hayes (wife) 563 Greenhill Ave. Balto.Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
nore	1x Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Druid Ridge Cem. Apr. 24, 2009 Balto, Md.	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home	
	1 23a Part I Foter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	
Physician Medical	failure. List only one cause on each line. Between Onse Death Immediate Cause (Final disease a, Gunshot Wound of Chest	at and
caminer	or condition resulting in death) Due to (or as a consequence of):	
4	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted Insit	c. Due to (or as a consequence of):	
and transit	d.	
60, ate be execu bhysician and burial - tra	UNPENDED AMENDED	
x 687 1 certific ending p use as th	FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. D	ar
P.O. BOY that the deatl ned by the att detached for		
ords, P.O. In requires that the as been signed by the should be detached by the property of t	1 Yes 2 No 3 Probably 4 Unki	
Division of Vital Records, P.O. rate of a vite ding Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Commisted by B.	24a. Was an autopsy findings av prior to completion of cau death? 1 ✓ Yes 2 No 1 ✓ Yes 2	
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical 20. Place of Death (Check Only Only) Page 10 Page	
nd of Vinding Physich.: After this efuneral dir	1 V Yes 2 No Present 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
Division o spital or Attending hours after death. meral Director: After y filled in by the fune	Apr 18, 2009 0645 hrs Apr 18, 2009 0645 hrs Suicide 6 Could not be determined 4 Homicide Apr 18, 2009 0645 hrs Suicide 6 Could not be determined Specify Local Street Speci	∍r, City
To the Hospital within 24 hours To the Funeral completely filled	2ga. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2gb. Signature and title of certifier 2gc. License number 2gd. Date signed (Month, Day, Year)	
F S F S	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2009	
	30. Name and address of person who completed cause of death (Item 23a)	
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat		
Registra DHMH 17 Rev 1/200	AFR 2000 p. Marie	

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		State of Maryla	•	artment of He r <i>tificate of D</i> e		•	_	0.00	1001
		Registrar 1. Decedent's Name (First, Middle, Last)		inicate of B	Catri	2. Date of De	Reg. No.	1111	2 Time of Death
Physici	ian					Month	Day	Year	5. Time of Death
/Medi		Thangam Ranga Iyer 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	nation of Dooth	April 1			5:20 A M
Examir	ner			"	_			nty of Death	0 ! -
	-	Shanti Home 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	Laure	L f Under 24 Hrs.	8. Date of Bir	th		George's
Funeral Director		1 □ M 28□ F	Yrs.		Hours Min.	(Month, Da	y, Year)	Coui	ntry)
		579-68-6611 85 Usual Residence of Decedent				April 2	1923 و 2.)	India
ylanc **		10a. State 10b. County 10c.	City, Town or Lo	cation				1	0d. Inside City Limits
Mar a-f st	ţ	Maryland Howard	E11i	cott City					1 □ Yes 2 🛣 No
r 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cour	ntry?
is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatte event, the Madical Examination at the rediffied at		10201 Tuscany Road		2104	2		Uni	ted St	ates
deat	Funeral	11. Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,		ecify Yes or No		Race - Americ	can Indian,
after or ite		Armed Forces? 1 ▼Never Married 2 Married 1 ▼Yes 2 ▼No				Hican, etc.)		Black, White,	
ral",	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □Yes 2 🗓 No	Specify:		Spe	cify: Asia	n-Indian
72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	on ina mast of work	ina	16b. Kind of	Business/In	dustry
thin he.	du	Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done dur OO NOT use retired)	ing most or work	"ig			
ygier ygier t, th	S	5+	Lil	orarian			US Go	vernme	ent
d oth	Be	17. Father's Name (First, Middle, Last)		11	3. Mother's Nam	e (First, Middle,	Maiden Surr	ame)	
Men Men arke	ဥ	Ranga Iyer			Che	11am	Amma1		
2 sho		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and	d Number or Rui	al Route Numbe	er, City or To	vn, State, Zip	Code)
and ealth n 27 ner tr		Shanthi Subramanian/niece		Marbury Ro	oad Bet	hesda,	Mary1a	nd 208	317
ges 1 nt of H if iter or oth		20a. Method of Disposition 20th 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	 Place of Dispo cemetery, crer 	sition (Name of natory or other place)	į	Date	20c. Locatio	n - City or To	wn, State
permit. Pages Department of Important: If It any injury or o			Arundel	Cremator	y April	21,09	0dent	on, Ma	ryland
port port y inj		21. Sign three of Funeral Service Licensee	22	Name and Address Onaldson	of Facility	Home &	Cromat	ory I	ο Δ
9 9 E 8 9		Quanta R Homas M	00957 1	411 Annapo	olis Roa	d Odent	on, Ma	ryland	21113
		23a. Part 1. Exter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ent	er the mode of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final	-i Co	mdforrage1	om Disco			9	Onset and Death
/Medical		disease or condition resulting in death) a. Hyperter Due to (or as a cons		rdiovascul	ar Dise	ase		-	Many years
Examiner			,						
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ian a		resulting in death) Last Due to (or as a cons	equence of):						
physician and s the burial-transit	dical	d							
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been signed by the attending should be detached for use as	sician/Me	23b. Was decedent pregnant 23c. If yes, outcome of preg		Ectopic pregnancy				Date of delive	,
ne at ed fo	sicis	1 Yes 2 No 4 Pregnant at time of		Other (specify)				Month	Day Year
by thach	Phys	9 Li Unknown							
as been signed by the attending 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not r	esulting in the ur	nderlying cause given	in Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
en si		Dementia				1 🗆 \	′es 2∏ No	3 ☐ Prob	ably 4 🕅 Unknown
has be e 2 sho	Completed					24a. Was	an 24	b. Were auto	psy findings available mpletion of cause of
ite ha	E						rmed?	death?	
tor, p	a)	25. Was case referred to medical		20	6. Place of Deat	1 ☐ Yes	2XINo	1 🗆 Yes	2 KINO
s cer	Ö	examiner? 1 ☐ Yes 2 【 No Hospital: 1 ☐ Inpatient 2	☐ FB/Outnatien	Othor				Othor (Case)	Group Home
er thi	Certification: To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury a Work?		28d. Describe h			y Group nom
th. : Aft	iţi.	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		s 2 🗆 No				
ctor	fice	3 Suicide 6 Could not be 28e, Place of Injury - At	home, farm, stre	eet, factory, office				mber or Rura	l Route Number,
after Dire	erti	4 Homicide determined building, etc. (Spe	cify)			City or Tou	n, State)		,
to the tropping of wideland Priysteran. The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, death	occurred at the time.	date and place.	and due to the	cause(s) and	manner as s	tated.
e Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	nation and/or in	estigation, in my opin	ion, death occur	red at the time,	date and plac	e, and due to	the cause(s)
Vithin comp	Me	29b. Signature and title of certifier		29c. License n	umber		29d. Date sig	ned (Month,	Day, Year)
-,- 0		Plan a man		D0010	1		A == == = 1	20 0	000
		30. Name and address of person who completed cause of death (It	om 22a) /Time 1	D2318	1		April	20, 2	009
0/		R. G. Bhojraj, M.D. 704 Gorma			aurol :	Marulan	4 2070°	7	
, 0			^ v = 1111						
Sta	te	31. Date filed (Month, Day, Year) APR 2 2 2009			aurer,	mar y ram	u 2070		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ACKSON a APRIL 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner TIMURE C MOSPITAL FBALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 M 2 F June Director Usual Residence of Decedent 10c. City, Tolvn or Logation 10d. Inside City Limits 10a. State 10b. Count 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director deni 10g. Citizen of W 10e. Street and Number ō "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify à 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indu 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Vurse 18. Mother's Name (First, Middle, Majden Surname, 17. Father's Name (First, Middle, Last) ACKSON thrabelle ou: ပ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 is i
any Injury or other traui
once. land Baltimore, 20b, Place of Disposition (Name of cemetery, crematory or other 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Iday /Medical Due to (or as a consequence of): Examiner to Equentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 6 140 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□** Mo J☐Inpatient 2☐ER/Outpatient 3☐DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred N⊒Natural 5 Pending investigation 1 ☐ Yes 2 Accident Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Low 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar KANT

alasen

Known

32. Registrar's Signature

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			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		/lental Hyglei .Reg.	0000	10051
			Decedent's Name (First, Middle, La	st)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		MARGARET	ANN	JOHN.	JSON		APRIL 18	3,2009	7:00 A M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	₹	4b. City, Town,	or Location of Death	,	4c. County of Death	MORE
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday	/) If Under 1 Year		8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		219-66-7020	□ M 2 X F	53 Yrs.	Months Days	Hours Min.	FEB. 12,19		RYLAND
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				I0d. Inside City Limits
	a-f sh	ctor	MARYLAND N/A		BALT	IMORE				1 Yes 2 □ No
	vith the	Director	10e. Street and Number		STREET	10f. Zip Code	1217	1	Citizen of What Cou	ntry?
	death v	Funeral	1832 DIVIS	12. Was Decedent			Hispanic Origin? (Span, Mexican, Puerto		14. Race - Ameri	
98	be filed within 72 hours atter death with the Maryland ital Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Mcdical Evaining rutel by houthlest at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No	If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White,	etc.
5-0036	hours tural",	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dec	edent's Usual Occu	pation	16b	. Kind of Business/In	dustry
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Maryland	12 should be filed with and Mental Hygie 7 Is marked other thraumatic event, the	To Be	17. Father's Name (First, Middle, Last, CHARLES F		NSON	SR.	18. Mother's Nam	e (First, Middle, Maid		RRIS
aryl	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other traumatic	۲	19a. Informant's Name/Relationship (ling Address (Stree		ral Route Number, Ci		
	1 and 2 Health tern 27 I			INSON GI						21217
altimore,	ages 1 ent of H t; If iter y or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		1	position (Name of ematory or other pla		- ,	Location - City or To	MARYLIAID
altin	permit. Pages 1 Department of F Important: If ite any Injury or ot once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices			22. Name and Addr				
ä	an in De	(i) 1	1 Dietvick	N. Will	liano s	140 N.FU	LTON AV	N JR. F E., BALTIN	nort, MD	21217
		0.0	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. Do not e	nter the mode of dy	ing, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
do.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LUNG CA	NCER a consequence of):					
	Examiner		Sequentially list conditions,	h.						
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89 x	ertifica ding ph	Med	IF FEMALE:	OGo If was autooms	of avagage					
Вох	The law requires that the death certificate be ate has been signed by the attending physicia agge 2 should be detached for use as the burn	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No	4 🔲 Pregnant a	2 Fetal death 3	Ectopic pregnan	су		23d. Date of deliv	Day Year
P.O.	at the d	hysi	9 ☐ Unknown	9 🗆 Unknown						
Js,	ires tha signed I be dei	δ	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause g	iven in Part I.	23e. Did tobac	co use contribute to t	the cause of death? bably 4 Unknown
Records,	w requir been s should	eted						24a. Was an		opsy findings available
Re	: The law cate has	Completed						autopsy performed 1 □Yes 2 X	prior to co	empletion of cause of
Vital	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?					th (Check only one)	110 10165	2 🗆 110
of	this al dir	ပ္	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji	ent 2 ER/Outpati	ent 3 🗆 DOA	_	ome 5 Residence		fy) HOSPICE
ion	Ing Afte une	Certification:	1X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	ay, Year) Injury	Wo	ork? □Yes 2□No	Zog. Bosonbe now i	njury occurred	
Division	after death after death Director: /	tifica	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of In	jury - At home, farm, s tc. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rur	al Route Number,
Ō	pita burs eral fille		29a. Certifier 1☐ CertifyIng P		of my knowledge, de			and due to the caus	se(s) and manner as	stated
	e Hosp 1 24 ho e Fune	edical		miner: On the basis	of examination and/or					
_	To the Ho within 24 h To the Fu completely	Me	29b. Signature and title of certifier			29c. Licer	nse number	29d.	Date signed (Month	Day, Year)
	A 1		1 CHARLE	KNP		131	149746	4	1/10/200	9

State Registrar

APR 2 2 2009 DHMH 17 Rev 1/2001

JACKIE JONES, CRNP
31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD. 32. Registrar's Signature

30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

09-03129 Bru

uce Alan Jett		State of Maryland / Department of Health a			0 1205
		- For State Certificate of Death	R	Reg. No. 200	
Physiciar edical Examin	1/	Decedent's Name (First, Middle,Last)	2. Date of Dea Month April 19, 2	ath Day Year	3. Time of Death 1004 hrs
eulcai Examini		Bruce Alan Jett 4a. Facility Name (if not institution, give street and number) 4b. City, Town	or Location of Death	4c. County of Death	
	ı	Carroll Hospital Center Westmin	ster	Carroll	
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1. Months [Save Utarre Min	irth(MM/DD/YYYY) 9. Birtl Foreign	1
Director	L	220-56-9219 11 M 2 F 57 Yrs.	0ct.	10, 1951 con	intry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* *	اي	MD Carroll Syk	esville		1 Yes 2 X No
ne Maryland or 28a-f show Ged at once.	Director	10e. Street and Number		10g. Citizen of What Coun	-
vith the Maryland s 23a or 28a-f show			1784	lad Dana America	USA
ath wit	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify C.	Hispanic Origin? (Specify Yes or Ni Iban, Mexican, Puerto Rican, etc.)	lo- 14. Race - Americ White, etc.	can Ingian, Black,
fter de		3 Widowed 4 Divorced If Yes, Give Year 1971-77 1 Yes 2 X	No specify:	Specify: Whit	e
ours a	leted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ during most of working	upation (Give kind of work done life. DO NOT use retired)	16b. Kind of Business/l	ndustry
36 in 72 h	let let	Elementary/Secondary (0-12) College (1-4 or 5+)		Home Impro	vement
d with ygiene ther t	Comp	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,		
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Be	Clarence Jett	Betty John		
D 21 Should and Me	잍	(Spouse)	treet and Number or Rural Route Nur Road Sykesvill		, Zip Code)
and 2 shoul lealth and N tem 27 is n traumatic	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	Town, State
Aore ages 1 nt of H nt: If i	- 1	1 Burial 2X Cremation 3 Removal from State crematory or other place) All County Crema	tion 4/25/2009	Sykesville	. MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medial programs.	1				,
M P P III		Briand Haight MOD 69 PO Box 1	UNERAL HOME & CH 95 Sykesville, M	D 21784	According to below
Physician Medical	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of diffillure. List only one cause on each line.		irrest, snock, or neart	Approximate Interval Between Onset and Death
kaminer	- [Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Due to (or as a consequence of):	Disease		
		Sequentially list conditions, b			
	ig	if any, leading to immediate cause. Enter Underlying Clause CSSSS Cause CSSSS Cause CSSSS Cause CSSSS Cause CSSSS Cause CSSSSS Cause CSSSS Cause CSSS Cause CSS Cause CSSS Cause CSS Cause CSS Cause CSSS Cause CSS			
pa sit	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
		d. UNPENDED AMENDED			
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tox 68760, eath certificate be attending physici for use as the buri		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify,	3 Ectopic pregnancy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	ysici	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Specify,			
P.O. Ess that the d	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying ca		tobacco use contribute to	
ords, P.C.			24a. Wa		utopsy findings available
cords law requi	Completed		per	rformed? death?	completion of cause of
tal Rectinn: The		25. Was case referred to medical 26.	Place of Death (Check only one)	s 2 No 1 Y	es 2 No
Vital hysician this cert	o Be	examiner? 1. ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	(Other:	Residence 6 Other	er:
ing Phy After tl	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. (Month, Day Year)		oe how injury occurred	
ttendi death.	atio	Natural 5 Pending 1 Accident Investigation	Yes 2 No		Doub Number Oite
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should lead in by the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town	n (Street and Number or R n, State)	urai Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifying Physician: To the best of my knowledge, death occurred at the time	ne, date and place, and due to the ca	ause(s) and manner as sta	ted.
To the within: To the comple	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my or and manner stated.			
	Σ		oc.M.E.	29d. Date signed (Mi	onur, Day, rear)
		30. Name and address of person who completed cause of death (Item 23a)			
6 V			et, Baltimore, MD 21201		
		(Acc 5) it had Street at			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Frank Aarne	e Kom	nulai	nen S	tate of I	Maryland	l / Dep	artme	nt of	Health	and	Menta	al Hyg	iene		0.0	0.0	1001
		·	For State			Ce	ertificat	te of	Death					g. No.	20	3. Time of D	Death 28
Phy Medical Ex	/sicia	n/ i	. Decedent's Name (First, Mide Frank Aarne		ainen								Month April 13, 20		Year	1503 h	
Medical	Kallilli		a. Facility Name (if not instituti			er)		41	c. City, Tow	vn, or Lo	ocation of		, , ,	4c. C	ounty of Deat		
			2805 Alden Road						Parkville				(D)		timore Co	•	o or Foreign
Fun			5. Social Security Number	6. Sex	7.7	Age (In yrs	. last birtho	day)	If Under	1 Year Days	If Under Hours	1.0			C	rthplace (Stat ountry)	
Dire	ctor		008-36-3864	1_ X M	2F	61		Yrs.					Januar	y 12	,1948	Connec	ticut
	any		Jsual Residence of Decedent 10a. State 10b. Count	<u> </u>		10c. Ci	ty, Town o	r Locatio	on							10d. Inside	City Limits
75	₹			alto.				Par	kvill	e							2 X No
arylan	8a-f sl	Director	10e. Street and Number						10f. Zip C				1	0g. Citize	n of What Co		
the M.	Dependent of recent and recent repeated by the continuers of tiems 23a or 28a-f show a propertiest litem 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmitteevent, the Medical Examiner must be notified at once.	嵩	2805 Alden Ro	ad						234					USA		
y haith	ms 23 be no	Funeral	11. Marital Status		. Was Decede Armed Force		U.S.	13. Was	s Decedent es, specify	of Hispa Cuban,	anic Origi Mexican,	n? (Spec Puerto Ri	cify Yes or No ican, etc.)	- 14	4. Race - Ame White, etc.	erican Indian,	Black,
r death	or ite	핆	1 Never Married 2	14	Yes	2 No		1	Yes 2X	No	specify:			s	pecify:	White	
rs afte	ura!",	à	Widowed 4 X II. 15. Decedent's Education (S		es, Give Year] (Dates: ighest grade		16a. D	eceden	t's Usual O	ccupatio	on (Give k	ind of wo	rk done		nd of Busines		
2 hou	"nat	eted	Elementary/Secondary (0-1		College (1-4		ا ه		ost of worki	_							
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5-0 iled w	d othe		17. Father's Name (First, Midd							1			L Meyei		umame)		
21215-0036 vold be filed within 7 Menral Hygiene	narke	To Be	Aarne K. Komu			_	19b	. Mailing	Address	(Street					or Town, Sta	ate, Zip Code)	
MD 2	27 is n	۲	Claire Komula		S-I	-L] {	8 Kr	ister	Ct	. Ea	ast 0	Greenbu	ısh.	New Yo	rk 120	61
e, N	item r tran		20a. Method of Disposition		Daniel from				sition (Name her place)	e of cem	netery,		Date	20c. Lo	ocation - City	or Town, Stat	е
nor	nt: If		1 X Burial 2 Cremate 4 Donation 5 Other		Removal from	Cale		-	Fores	s t			,2009			lls, Md	l
Baltimore,	parun porta ury o		21. Signature of Funeral Serv						Name and A						unera.		
m § 8	Z E E		Becau G. 23a. Part I. Enter the disease	بعاليا	lle	and the de	oth Dono	t enter t	9705	Bel	air l	Rd.	NOTT1	nghan rest, shoo	n, Md.	Z I Z 3 O Approxi	mate Interval
Phys	ician cical		failure. List only one cau	ise on each	line.												en Onset and Death
	niner		Immediate Cause (Final diseasor condition resulting in death	ase a. Due	Athero:	SICET onsequence	otic ce of): by	car 7 hy	<u>olova</u> pothe	rmia	ar c	iisea	ise con	рттс	aceu		
			Sequentially list conditions,	b										_			
		iner	if any, leading to immediate cause. Enter Underlying Cau	se	e to (or as a c	onsequen	ce of):										
	.=	Examine	(Disease or injury that initiate events resulting in death) La	D.,	e to (or as a c	onsequen	ce of):										
executed	and - transit		Y	d	AMENDED 2	3a,PI	1,27	, 28a	−f,pe	rME	, g89	0 4/	23/09	TT		+	
	5 5	edical	X UNPENDED												I. Date of deli	very	
Division of Vital Records, P.O. Box 68760,	attending physici for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the	23c. If yes, or		pregnancy		etal death	3	Ectopi	ic pregna	ncy		Month	Day	Year
ox 6	attendi or use	sicia	1 Yes 2 No 9	Unknown	T = 1	nt at time o	of death	5 C	ther (Spec	cify)							
. B o	y the a	ן >	Part II. Other significant co	,	g Unknow		not resultir	ng in the	underlying	cause	given in P	art I.				e to the cause	
P.O.	signed by t I be detache	<u>۾</u>	Charanta al										1 \	es 2	No 3	Probably 4	Unknown
ds, require	s been si should b	Completed	<u> </u>										24a. Wa	as an topsy		e autopsy find to completion	lings available n of cause of
cor e law	certificate has bector, page 2 sh	d E												rformed?	deat	h? Yes	2 No
~ = =	his certificate l director, page	ပ္ပြ	25. Was case referred to me	dical						26.Place	e of Death	n (Check	only one)				
Vita ysicha	his ce direct	o Be	examiner? 1 Yes 2 No	Ho	spital: 1 Ir	patient :	2 ER/0	Dutpatie		DOA	Other ₄		ng Home 5		ence 6 🗸 (Other: Scene	
of and	After this funeral dir	=	27. Manner of Death			Day,Year)		. Time o	· · ·		ury at Wor Yes 2	1	subje	ct ex		to low	
sion ttendi	death.	iati	1 Natural 5	Pending Investigatior		/13/0			9 pm				envir	onmet	ntal to	emperat or Rural Route	Number, City
Division of Vital Records, lad or Attending Physiciau: The law requir	nours after do neral Direct filled in by	Certification:	3 Suicide 6	Could not be determined	9		yard			y, omce	Dunumy,	Cic.	or Town Parky	ille	2805 A. , MD	Lden Ko	1
Ospita	within 24 hours after death To the Funeral Director: completely filled in by the	\ <u>\</u>	4 Homicide 29a. Certifier 1 Certifivi	- Dhuaisia	To the hes	of my kno	wledne d	eath occ	curred at th	e time, c	date and p	olace, and	due to the c	ause(s) a	nd manner as	stated.	
= = = = = = = = = = = = = = = = = = =	within 24 h To the Fur completely	edical	(Check only one) 2 Medical	Examiner:	on the basis of	of examinat	tion and/or	investig	gation, in m	y opinio	on, death o	occurred a	at the time, d	ate and pi	ace, and due	to the cause(s	
· ·	29b. Signature and title of certifier								Year)								
			Manh	iasi2	U, M.	113				0.0	.M.E.			Ар	ril 14, 200	ə 	
_			30. Name and address of pe					111	Penn S	treet	Baltimo	ore MD	21201				
			Melissa Brassell,		sistant Me	gistrar's S				acct,	Dalaine	0, 1410				 	
	Regi	Stat istra				me	A.	pa	aked								

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Christopher Lee Keesler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 12854

			1- For State Cert	tificate of Death	Reg. No.			
ŗ	Physicia al Exami	an/	1. Decedent's Name (First, Middle,Last) Christopher Lee Keesler	2. Date of Death Month Day April 18, 2009	3. Time of Death O653 hrs			
	1		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Randallstown	4c.	County of Death altimore County		
	_		Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. la		DD/YYYY) 9. Birthplace (State or			
	Funeral Director		213-02-0629 1 M 2 F 26	_	05/17/1982 Foreign CountryMaryland			
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits		
1		- 1	MD Baltimore	Lang Cities	1 X Yes 2 No			
3	the Mary Sa or 28a- otified at	Dire	10e Street and Number 8627 Liberty Road, 2nd Floor		S.A.			
1	5-0036 led within 72 hours after death with the Maryland stygiene other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Rican, etc.)	14. Race - American Indian, Black, White, etc.			
	15-0036 filed within 72 hours after I Hygiene dother than "natural", of, the Medical Examiner?	畜	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of v		Specify: White		
	2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti		·		
	21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	ompleted	9	Salesperson		les		
	15-0 iled w Hygie d othe	ပ၂	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden \$	Surname)		
	d be fenta	o Be	Unknown 19a. Informant's Name/Relationship (Type, Print)	Terry Ke		ty or Town, State, Zip Code)		
	MD 2 d 2 shou lth and N n 27 is n	2	Stephen Keesler/Uncle	5 Manor Place, Roseda				
	e, MD 1 and 2 sho Health and item 27 is r traumati		20a. Method of Disposition 20b. F	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. L	Location - City or Town, State		
	imore, MD 2 Pages I and 2 shoul nent of Health and M ant: If item 27 is m or other traumatic		Bullal 2 Clellation 3 Removal non State	nt Cremation Services 04/2	22/2009 На	nover, Maryland		
	Baltimore, permit. Pages 1 at Department of Her Important: If ite	Ì	21. Sign of e of Funera ervice cersee	22. Name and Address of Facility Arc				
			23a. Part I. Enter the disease, or complications that caused the death.	7522 Connelley Dri				
	Physician Medical zxaminer		failure. List only one cause on each line.	alcohol intoxication;		Between Unset and		
	xaiiiiiei		or condition resulting in death) Due to (or as a consequence of	f):				
		Je .	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	f):				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated purpts regulting in death). Last Due to (or as a consequence of	f):				
	uted nd ransit		d					
	e exec cian al rial - t	/Medical	X UNPENDED AMENDED 23a,27	,28a-f,permE, g891 5/2	1/09 TT			
	ficate be executed g physician and the burial - transit	/We	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregi	nancy 2 Fetal death 3 Ectopic pregn		d. Date of delivery Month Day Year		
	Box 68's death certificate attendings	Physician	past 12 months? 4 Pregnant at time of de		aricy	Month. Bay roa		
	Bo; ie deatl the att	hys	1 Yes 2 No 9 Unknown 9 Unknown		220 Did tobacco	use contribute to the cause of death?		
	P.O. that th	by P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.		No 3 Probably 4 Unknown		
	ords, I	Completed			24a. Was an	24b. Were autopsy findings available		
	COF	mple			autopsy performed?	prior to completion of cause of death?		
	tal Re(sian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 N	lo 1 Yes 2 No		
	Vita ysician his cer direct	o Be	evaminer?	ER/Outpatient 3 DOA Other Nurs	ing Home 5 Reside	ence 6 Other:		
	ing Ph After t funeral	n: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how inju	ury occurred		
	sion ttend death. ctor: y the f	atic	Accident Pending Fd 4/18/09	Fd 6:10 am 1 Yes 2 X No		and Number or Rural Route Number, City		
	Division of Vital Records, Priptal or Attending Physician: The law requires the ours after death. Reral Director: After this certificate has been signe filled in by the funeral director, page 2 should be d	Certification:	3 Suicide 6 X Could not be determined (Specify) Hou	ome, farm, street, factory, office building, etc.	or Town, State) 3 Randallsto	and Number or Rural Route Number, City 3526 Millvale Rd Dwn, MD		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled one) Medical Examiner: On the basis of examination a	ige, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	at the time, date and pla	nd manner as stated. ace, and due to the cause(s)		
	T _o	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day						
•			Mayonte The Yeall	O.C.M.E.	Apr	ril 19, 2009		
			30. Name and addless of person who completed cause of death (Item Margarita Korell MD. Assistant Medical Examir) 21201			
li		tate	31. Date filed (Month, Day Year) 32. Registrar's Signatu	ure _				
	Reais	tate	1 7 7 7 7 7 7 7 7	Sake				

			For State Registrar	State of M	1 aryland		artmeni rtificate			nd M		jiene leg. No. (2009	12855
	Physici	an	1. Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	Day	Year	3. Time of Death
-	/Medio	cal	Satp 4a. Facility Name (If not institution, give		akar		41. 0:1	Fa	I otion of	Dooth	April	21,	2009	12:58 P ^M
	Examir	er	Shady Grove Adve	entist Hos	spital			Roc	Location of	Le			ounty of Death	mery
	Funeral Director		5. Social Security Number 6. 8 212-08-3371	Sex 7.4 1 1 XДM 2□F	ige <i>(In yr</i> s. <i>la</i>	as <i>t birthday)</i> Yrs.	If Under Months	Days	If Under 2	Min.	8. Date of Birth (Month, Day 09-10-1	Year)		place (State or Foreign intry)
			Usual Residence of Decedent		90						09-10-1	. 910	Pak	istan
	arylan show	-	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	he Ma 28a-f	Director	MD Montgor	mery			10f. Zip		ksbur	g		10 - O't-	(140) -1 0	1 □Yes 2X No
	with 1	ä	12112 Cypress Sp	rine Dond	ı		101. Zip		0871				en of What Cou ited St	·
	ms 2;	Funeral	12112 Cypless Sp	12. Was Deceden	t Ever in U.S	5. 13.	Was Deced			in? (Spe	cify Yes or No- Rican, etc.)		I. Race - Amer	ican Indian,
98	after or ite		1 Never Married 2 Married	Armed Forces 1 Yes 2 N		1	ifYes,spec 1 □ Yes 2		n, Mexican, Specify:	Puerto F	(lican, etc.)		Black, White,	etc.
9	hours ural",	d by	3	Year or Dates	:									Asian
15	in 72 n "nat ledica	plete	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	urina most d	of workin	g	16b. Kind	of Business/Ir	ndustry
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23a or 28a-f show snt, the Medical Exeminer must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		Self -					В	everage	2
p	e file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle,	Maiden S	urname)	
yla	ould the market	ပ္	Gurdial Kakar					}		-	Kakar			
Maryland	d 2 sh th and 7 is n traum		19a. Informant's Name/Relationship				-						Town, State, Zi	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	1	Amarjeet Kakar / 20a. Method of Disposition	Son	20b. Pl	L 1211 ace of Dispo	.2 Cyp sition (Nam	ress	Spri		toad Cla		urg, Ma ation - City or T	aryland 2087 own, State
m 0	Pages nent of nt: If i		1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		e				i i	/ ₄ - 2 3	-2009	Oden	ton, Ma	ruland
Baltimore,	permit. Departm Importa any inju		21. Si pature of Funeral September Line	-	/								matory,	
<u>m</u>	8 3 E 8	. 0	Calla	Delle	est	(2)	1411	_Ann	iapo11	s Ko	ad Uder	iton,	Maryla	and 21113
н			23a Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	. Do not ent	er the mode	e of dying	g, such as c	ardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Муоса		. Infa	rcti	.on					1 week
7	Examiner				s a consequ		+10							11-
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		c Chole		tis							l week
	cuted nd ransit	Examiner	that initiated events	c										
90,	sian a urial-t	Ex	resulting in death) Last	Due to (or a	s a consequ	ence of):								
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and adjector, page 2 should be detached for use as the burial-transit	dical	•	d										
9 X	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnar	ncy		-				22	d. Date of deliv	
. Box	death e atte	iciai	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of de		☐ Ectopic pr ☐ Other (spe					20	Month	Day Year
P.O.	that the de ned by the detached	hys	9 Unknown	9 Unknown										
	ires tha signed 1 be det		Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying ca	use give	n in Part I.					the cause of death?
Records,	w requir s been s should	Completed by				·					1 🗆 Y	es 2 🔼	.No 3☐ Pro	bably 4 Unknown
3ec	e law has b	m pk						-			24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
<u>a</u>	n: Th ficate r, pag		05 141	1							perfor 1 □ Yes	2 X No	death? 1 □ Yes	2XNo
of Vital	hysician: The la his certificate ha I director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	tient 2 🗆 8		at 2 🗆 🗆	Othe	r.		(Check only or		☐Other (Spec	26.3
	r Attending Phy ter death. irector: After this by the funeral of	n: To	27. Manner of Death	28a. Date of Ir (Month, D	ijury	28b. Time o		Bc. Injury Work			8d. Describe h			ny)
Division	Attending or death. ector: After by the fune	Certification:	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	yay, rear)	injury	М		es 2□N	ю				
Ξ̈́	l or Attend after death Director: /	rtific	3 ☐ Suicide 6 ☐ Could not be determined	1 28e. Place of I	njury - At hor etc. <i>(Specify</i>	ne, farm, str	eet, factory,	office		2	8f. Location (S City or Tow		Number or Rui	ral Route Number,
	Hospital c 24 hours at Funeral D stely filled i		29a. Certifier 1 X Certifying P	hysician: To the bes	et of my know	uledge doot	h o sourred	at the tim	a data and	d place of	and due to the	201100(0)		atotod
	To the Hospital or within 24 hours after To the Funeral Director completely filled in I	Medical	(Check only 2 Medical Exa	miner: On the basis and manner:	of examinati	ion and/or in	vestigation,	in my op	oinion, death	h occurre	ed at the time,	date and p	lace, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	01			29c	. License	number		2	29d. Date	signed (Month	, Day, Year)
	4		1 men	elle	سع	(10 m	UND	D382	262			Apri	11 21,	2009
	IV		30. Name and address of person who				,							
	Sta	te	A. Mendhiratta,] 31. Date filed (Month, Day, Year)		Resear strar's Signati	ch Bly	rd. Su	iite	330 F	Rock	ville,	Mary]	and	
	318	il.	, , , , , , , , , , , , , , , , , , , ,	4	A	had	1							

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryiand		tificate of	neaith and iv Death		gien Reg. N	2000	128	56	
	Physicia	20	1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea		ay Year	3. Time of Deat		
	Physicia /Medic	al		WN KESSLEI	R				APR	14	2009		» ^M	
	Examin	er	4a. Facility Name (If not institution, give		TOTAL STATE			Location of Death		40	c. County of Death			
_	Formeral		NATIONAL NAVAL M 5. Social Security Number 6. Se			t birthdav)	If Under 1 Year	THESDA If Under 24 Hrs.	8. Date of Birt	th	MONTGO 9. Birtl		eign	
	Director	Funeral 3231 (9 571) 1 M 2 XF (7 Wonths Days Hours Min. T. (Month, L							Jan. 1	0,	1962 De	nplace (State or For- intry) Laware		
	rland ow	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Lin	nits		
	Many a-f sh	ctor	Maryland Kent		Mi1	lingt	on			1X∏Yes 2 □ No				
	th the	Dire	10e. Street and Number				10f. Zip Code			•	citizen of What Co	untry?		
	ath wi	ral	P.O. Box 300				21651				S.A.			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Eventinal must be indified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1			Vas Decedent of H fYes, specify Cuba □Yes 2XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Ye's or No Rican, etc.)	•	14. Race - Ame Black, White Specify: Whi	, etc.		
2-0	72 hor	ted	15. Decedent's Ed	ucation		16a. Deced	lent's Usual Occup	ation	ina	16b.	Kind of Business/I			
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)			during most of work d)	9			A 77		
121	led w tygier her th		47 Fallenda Name / First Middle poth	4		Nurs	e	18. Mother's Nam	o (First Middle			Ann Hosp	ıta	
Maryland	l be fi intal h ed ot	Be o	17. Father's Name (First, Middle, Last) Lemuel Mayle					Dolores		marac	in Cameney			
Ž	thould nd Me mark matk	၉	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	a Address (Street	and Number or Rui		er, City	or Town, State, 2	ip Code)		
	nd 2 salth ar		Michael J. Kessle		1)			Millingt						
re,	s 1 au of Hea item		20a. Method of Disposition	1			sition (Name of natory or other place		Date		Location - City or	Town, State		
Baltimore,	t. Page rtment c rtant: If rjury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	"		ris F	amily Cen	netery 4-1		Pl	hilippi,	WV		
Bal	permi Depar Impor any tr once.		21. Signature of Funeral Service Licensee Wright Tuneral Home 22. Name and Address of Facility Home 21. Signature of Funeral Service Licensee Wright Tuneral Very Home 21. Signature of Funeral Service Licensee Wright Tuneral Very Home 21. Signature of Funeral Service Licensee											
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lit	the death. ne.	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	1	
Physician Immediate Cause (Final disease or condition CORONARY ARTERY DISEASE											Oriset and Death			
4	/Medical Examiner		resulting in death)	Due to (or as										
Convertible list conditions														
	uted I Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240 10 (01 40	u 001100 que	.,,,,								
Ć.	tificate be executed ig physician and as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as	a conseque	nce of):								
68760,	ysicia ysicia	cal	•	d										
	rtifica ng ph as th		IE EENAAI E-	-=										
O. Box	w requires that the death cert been signed by the ettendin should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 딦No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	death 3	Ectopic pregnand Other (specify)	СУ			23d. Date of del Month	ivery Day Year		
ds, P.	res that signed b		Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the u	nderlying cause giv	ven in Part I.				the cause of death		
Ö	requi	eted									1			
Vital Records,	stclan: The law certificate has t irector, page 2 sl	Completed by							24a. Was auto perfo	psy ormed?	prior to death?	topsy findings avail completion of cause 2 XNo	able of	
ita	iding Physician: th. After this cartifica funeral director, p	Be C	25. Was case referred to medical examiner?					26. Place of Dea	1 1					
of V	Physician: this certific		1 Yes 2 No				IL 3 LI DOA				6 ☐ Other (Spe	cify)		
n o	ling P	ion	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 2 ay, Year) 2	28b. Time o Injury	Wor		28d. Describe	how in	jury occurred			
Division of	Attending r death. sctor: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Inj			eet, factory, office]Yes 2□No				ıral Route Number,		
Ο̈́	s efter s efter al Dire ed in b	Certification: To	4 ☐ Homicide determined	building, et	tc." (Specify)				City or To	wn, Sta	ate)			
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical		nysician: To the best niner: On the basis of and manner st	of examination									
	To the within To the Complex c	Me	29b. Signature and title of certifier	101	mD		29c. Licen	se number			Date signed (Mont			
			male for	ydou-			01055	5104A (IN)	Ap	ril, 15	, 2009		
			30. Name and address of person who	completed cause of	death (Item 2	23a) (Type,		NATIONAL				ΓER		
			MICHAEL BAYDAR	IAN LCDR	MC rar's Signa	USN	, del	BETHESDA	MD 208	89-	5600			
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 2 20	09 Legen	rar's Signa	190								

DHMH 17 Rev 1/2001

		1 – For State Registrar		laryland ,	-	rtment of F		and M		Reg. No.	2009	12857
Physicia	an	Decedent's Name (First, Middle			77.	1			2. Date of De	ath Day	Year	3. Time of Death
/Medic		Sue Ann 4a. Facility Name (If not institution	Lindge		K11	ndermann 4b. City, Town, o	r Logation o	f Dooth	April	()	2009	10:21
Examin	er	Shady Grove Adv	-			Rockvill		n Deam			unty of Death tgomer	v
Funeral			6. Sex 7. A	ge (In yrs. last	birthday)	If Under 1 Year	If Under 2		8. Date of Bir		0	-
Director		383-42-1593	1 □ M 21X F	63	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da Aug • 2:	2, ^{rear)}	5 Mic	place (State or Foreign htry) higan
tud •		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	nation					1	0d. In side City Limits
faryla i sho	5	MD Montgo	omery	North								1 □Yes 2 No
the N	rect	10e. Street and Number				10f. Zip Code			· · · · · · · · · · · · · · · · · · ·	10a. Citizer	of What Cour	ntry?
3a or	O E	13628 Glenhurst	Road			20878				-	d State	-
filed within 72 hours after death with the Maryland Hygiene. Hygiene with attention of them 23a or 28a-f show ant, the Medical Even increments to a patth of a	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces		13.	Was Decedent of F f Yes, specify Cubi	lispanic Orig	gin? (Spe	cify Yes or No)- 14.	Race - Americ	
or ite		1 Never Married 2 Marri			-	Yes 2 XNo	Specify:	, rueno r	nican, etc.)		Black, White,	
"natural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		0- D	I					VVII	ite
in 72 "nat	olete	15. Decedent (Specify only highes	t grade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most	of workin	ng	16b. Kind	of Business/In-	dustry
yiene giene r thai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+) S		stician	,			Fede	ral Go	vernment
e filec al Hyg r othe vent,	Be C	17. Father's Name (First, Middle, L	_ast)				18. Mother	r's Name	(First, Middle	, Maiden Sui	rname)	
Ment Ment arkec atic e	To	John Lindgren					Mary		llen	Glas		
2 sho and is m raum	9	19a. Informant's Name/Relationsh		. "		g Address (Street						
1 and Health		Charles Robert 20a. Method of Disposition	Kindermann	- 1-		528 Glent			——-			
permit, Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		1 ☐ Burial 2XXCremation	3 ☐ Removal from State	Cheen	etery, cren	sition (Name of natory or other place Cremato	ce)	-	1 ^{te} 22,		ion - City or To	
artme		4 □ Donation 5 □ Other (Sp. 21. Si Pature o Funeral Service L		Ciresa				200			ville,	on Service
permi Depar Impor any Ir		The Same		M009		933 Gist						
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death. [Approximate
Physician	i i	Immediate Cause (Final disease or condition		TEPEN	NA	ANIO SE	RIC	SYNI	DOME			Interval Between Onset and Death
/Medical		resulting in death)		s a consequen	ce of):	THOP SE	1)	- /1-//	45946			
Examiner	_	Sequentially list conditions.	D. INDU	HELLING	5 PA	AND SE	INTPI	AUE/	DUS 1	CATIH	ETER	
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequen	ce of):							
xecui and	xan	that initiated events resulting in death) Last	c Due to (or as	s a consequen	ce of):							
cate be executed oblysician and the burial-transit	ical		d		·							
tificat ig phy as the	ledic		U									
Attending Physician: The law requires that the death certificate be executed an death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal de		Ectopic pregnanc	ev.			23d	. Date of delive	•
e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ♠No		at time of deat		Other (specify) _	·y				Month	Day Year
d by t	Phy	9 Unknown		huit mat ro sulting	a in the con	alaskija – sama sir	on in Don't		One Did			
ires the signe	þ	Part II. Other significant conditio	l Cauce		ig in the ur	idenying cause giv	en in Part I.			Yes 221		he cause of death?
requ been should	Completed	- Z. S Of Can Jane		,	120							
he lav e has ge 2 :	dm			-		-			24a. Was autop	an 2 psy prmed?	prior to co death?	psy findings available mpletion of cause of
an: T tificat or, pa		25. Was case referred to medical					OC Diase	-4 D4	1 □Yes		1 □ Ye <i>s</i>	2 □No
yslcla is cer	o Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	ient 2□ER	/Outpatien	t 3 DOA Oth	or.		(Check only o		Other (Special	64)
ig Phr ter thi	Ţ:u	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj	jury 28	b. Time of	28c. Injui	ry at		28d. Describe			<i>y</i> /
endIr eath. or: Al	atic	2 Accident investig	ation	7, ,			Yes 2□N	No				
or Att fter de lirect	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	J Zoe. Place of In	jury - At home tc. <i>(Specify)</i>	, farm, stre	eet, factory, office		2	Ref. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physician. To the hoo	t of my knowle	dae desti			d alara			4	
24 hc 24 hc Fun etely	Medical	(Check only 2 Medical I	g Physician: To the bes Examiner: On the basis and manner s	of examination	and/or in	vestigation, in my	me, date an opinion, deal	d place, a th occurre	and due to the ed at the time,	date and pla	ace, and due to	stated. o the cause(s)
Fo the vithin Fo the somple	Me	29b. Signature and title of certifier	111	1		29c. Licens	se number	-		29d. Date s	igned (Month,	Day, Year)
		> Alux	1 Chou	Na		29	341	}		apric	(20,	209
		30. Name and address of person v	who completed cause of	death (Item 23	Ba) (Type,	Delat)				—		
10		AVAN CHAWAVE	1 15ms S	HADY (OPOV	E RO	ROCK	ville	= MD	208	550	
Sta		31. Date filed (Month, Day, Year)	Regist	iHADY (term 25)	ha	and a						
Registr	ar	APR 222	LUUS KENEW	v p.	190							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 0510 PM JOHN JOSEPH KROPFELDER APRIL2 2009 City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death (HOSP2TAL LTEMORE 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 XM 2 ☐ F Months Days Hours 95 213-03-3695 27,1913 MARYLAND MAY Usua! Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2X No BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country S. MORERICK AVENUE 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify Specify: WHITE Year or Dates: 1942-45 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

PIPEFITTER

OAK LAWN CEMETERY 4/23/09

20b. Place of Disposition (Name of cemetery, crematory or other place)

EXXON CO.

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21224

Approximate Interval Between

18. Mother's Name (First, Middle, Maiden Surname)

RUPP

MARY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 S. MORERICK AVE., CATONSVILLE, MD.

Date

22. Name and Address of Facility
22. Name and Address of Facility
700 S. & CONKLING STREET, BALTO., MB.

Physician /Medical Examiner

Physician/Medical Examiner

Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.

Physician

/Medical

Examiner

10a. State

MD

19

17. Father's Name (First, Middle, Last)

1X Burial 2 ☐ Cremation

4 Donation 5 Dother (Specify)

21. Signature of Funeral Solvice Licensee

19a. Informant's Name/Relationship (Type. Print)

NICHOLAS KROPFELDER/

KROPFELDER

BROTHER

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

GEORGE

20a. Method of Disposition

Director

Funeral

\$

Completed

Be

2

Funeral

Director

show

ir than "natural", or items 23a or 28a-f shooms than "notical Examinating the notified at

death with the Maryland

Baltimore, Maryland 21215-0036

burial-tra P.O. Box 68760 Records, funeral director,

Be Completed by

Certification: To

Medical

State Registrar 31. Date filed (Month. Day.

JAH OF Division of Vital Hospital or Attending

Immediate Cause (Final disease or condition resulting in death)	a ASPERATION PNEUMONEA	Onset and Death				
Sequentially list conditions, if any, learning to linthe diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SETXURP Could (or as a consequence of).	2DA75				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consequence of): d	23d. Date of delivery Month Day Year				
Part II. Other significant conditions of Old Off Devices	a, Athel Fibrilation, Hypertension, 104	bacco use contribute to the cause of death? es 2 ☑ No 3 ☐ Probably 4 ☐ Unknown				
Confestive He	autop					
25. Was case referred to medical examiner?	26. Place of Death (Check only of	ne)				
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resid	ence 6 Other (Specify)				
27. Manner of Death 1	ow injury occurred					
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)						
29a. Certifier 1	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	cause(s) and manner as stated. date and place, and due to the cause(s)				
29b. Signature and inte of certifier	29c. License number D 67-978	29d. Date signed (Month, Day, Year) APRIL (8 2009				
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	00 101 00				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 Apri1 16, Bernard Herbert Kernan, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□ F 3/22/27 Maryland 218-22-8307 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exprehen next be notified at 1 ☐Yes 2 No **Funeral Director** <u>Baltimore</u> Baltimore 10g. Citizen of What Country? 10e. Street and Number ŏ USA 21227 1266 Linden Avenue Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No
If Yes, Give
Year or Dates: 1947-67 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No ō Specify þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this and injury or other traumatic event, the once. United States Navy / Army Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Eyerly ٩ Herbert Bernard Kernan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2008 Farm Pond Ct. Reisterstown, Maryland 20622 Robert Luerssen, Jr. / Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/09 Baltimore, Maryland Loudon Park Cemetery: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending investigation 1 □ Yes 2 □ No hours after death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated

Records, Division of Vital within 24 hours a

P.O.

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

22 2009

30. Name and address of person who completed cause or death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral SEP 17, 1939 Months Days Hours Min MARYLAND 69 213-38-7055 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ient of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 Yes 2 No the Medical Examiner must be notified MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò items 23a 8218 ARROWHEAD ROAD 21208 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates 1 ☐ Yes 2X No 3 Widowed 4 Divorced WHITE 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry fe. DO NOT use retir HOMEMAKER Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than OWN HOME or other traumatic event, 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be MORRIS SHAPIRO MIRIAM GRUZIN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLE KLUPT/HUSBAND 8218 ARROWHEAD ROAD BALTIMORE, MARYLAND 21208 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department Important: I any injury o BALTIMORE HEBREW 04/21/2009 REISTERSTOWN, MD 4 🗆 Da 5 Other (Specify) Sign Bervice Lie SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disea Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death d the death. shock, or heart failure. List only one Immediate Cause (Final cancer **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To eral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 2 Accident 1 🗌 Yes 2 🗌 No death. 3 Suicide Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide after e Funeral 29a. Certifier (check only 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel within 2 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) MD RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Anthony 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar' State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G890, 4/22/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death APR 8, **Physician** Year 2009 11:00 PM Thomas Long Gary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 202 Sunny Brook Terr. #616 Gaithersburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 9, 9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs, last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. **Director** 50 <u> 215-74-4102</u> Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exactorization or other traumatic event, the Medical Exactorization or other traumatic event. 10d. Inside City Limits 1 Tyes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 United States Funeral 202 Sunny Brook Terr. #616 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceden. _ Armed Forces? 1 □Yes 2 XNo Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No White Specify 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Renovation Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joan Mathews ဥ Herman Clyde Long, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Sunny Brook Terr., #616 Gaithersburg, MD 20879 Monica Jones Long/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 11. 20c. Location - City or Town, State Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Straice Licensee 22. Name and Address of FacilityRapp Funeral & Cremation Service once. M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate performed 1 ☐ Yes 2 No 1 □Yes 2 NO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Structure of Structur မ 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 □Yes nours after death.

neral Director: /
filled in by the for 2 Accident 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

State 31. Date filed (Month, Day, Year)

Nelson G.N. Kalil, M.D.

5454 Wisconsin Ave., Chevy Chase, MD
32. Pegistrar's Signature

Divini A. Janes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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Physician

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Director

Funeral

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Certification: To

Medical

1 ☐ Yes

29a. Certifier

30. Name and address of person who condleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Robert Donegan

2 9 2009

31. Date filed (Month, Day, Year)-

24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 5:00 p^M IV 2009 Η. Lewis Henry April 16. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Reisterstown 6514 Deer Park Road If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1⊠M 2□ F Yrs 78 Dec. 28, 1930 218-26-8464 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Reisterstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21136 U.S.A. 6514 Deer Park Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No 1948— If Yes, Give Year or Dates: 1954 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced 1954 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Henry H. Lewis Contract Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Tase Henry Howell Lewis, III Isebella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet H. Lewis Wife 6514 Deer Park Road Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 4/20/09 Reisterstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road line Eline Funeral Home Reisterstown, MD Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma 3 a 19Nam Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No performed Yes 2 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 1 Inpatient Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0 0 5 6 9 19 29b. Signature and title of cactifier 29d. Date signed (Month, Day, Year) 09

Registrar

State

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6569 N. Charles Street Suite 205

21204

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Patricia Mejias-Vincent April 15 2009 1345 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of MD. Medical Center Raltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1/23/1953 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F 56 Director 217-21-3794 Trinidad Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits marked other than "natural", or items 23a or 28a-f shov imatic event, the Medical Examinar must be notified at Director 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2806 Ruscombe Lane 21215 Funeral Trinidad 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 X Yes 2 □ No Specify Specify: Black 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cricito Mejias May ပ Alexander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2
ant of Health an
ant: If item 27 is n Vincent/ Husband Stephen 2806 Ruscombe Lane, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any Injury or once. Anatomy Gifts Registry 4X Donation 5 ☐ Other (Specify) 4/20/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe bowel ischemia with necrosis hours /Medical Due to (or as a consequence of): Examiner Aortic and superior mesenteric ischemia/dissection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last days Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2 🔽 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Sepsis, severe multiorgan failure, severe coaqulopathy 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X** No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 🔀 No 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Iniun 1 X Natural 5 Pending investigation 1 ☐ Yes 2 \square No 2 Accident 6 ☐ Could not be 3 Suicide

death certificate be executed P.O. Box 68760. Division of Vital Records, or Attending Physician: Hospital

within 72 hours after death

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Pages 1 and

"natural", or

Maryland 21215-0036

Baltimore,

physician and s the burial-trans attending phase as the the detached p signed b peen has t page 2 certificate Certification: To this funeral After t within 24 hours after under the To the Funeral Director: Af 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 5

Jason ′Lai MD 22 S. Greene Street, Baltimore, MD 21201

State Registrar

22

31. Date filed (Month, Day, Year)

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea **Physician** Marche 11:25 A M Marian Graham 21, 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Towson Greater Baltimore Medical Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🔀 F 84 240-30-1081 Director 09/07/1924 NC Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Evandor, rust be notified Baltimore Owings Mills MD 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9411 Groffs Mill Drive 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Specify: Specify: White ۵ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Florist - Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental h permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Henry Lewis Janie Graham ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. Nielsen / 1427 Haubert Street, Baltimore, MD 21230 Niels Son altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 04/22/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services Po Box 1413, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** uno disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) hed by the a detached for 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🗷 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) Injury 5 Pending M investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 04/21/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROOD GREATE BALTIMORE Medical center, Baltmay, MD HAWA 7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 22 2009 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, C.

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Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signatule of Fun	eral Service Licens	See -			Name and Address 38 N. G					
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Вох	eath c attend for us	ian/	23b. Was decedent in the past 12 m	nonths?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at	2 🔲 Fetal	death 3	Ectopic pregnand Other (specify)	су			23d. Date of d Month	elivery Day Year
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oţ	Physer this eral dii	<u>ائر</u>	1 ☐ Yes 2 ☑ N 27. Manner of Death	10	28a. Date of Injur	у	28b. Time o	IL 3 LI DOA	4 Munsing i	Home 5 ☐ Res 28d. Describe			pecify)
ion	nding Ph ath. r: After th e funeral	atio	1 🔀 Natural 2 ☐ Accident	5 Pending investigation	(Month, Day	; Year)	Injury		ki? Yes 2 □No				
Division	or Attending after death. Director: After in by the funer	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju	ry - At hor	ne, farm, str	eet, factory, office		28f. Location	(Street ar	nd Number or F	Rural Route Number,
Ö	pital ol ours aft eral Di filled in		29a. Certifier	1☑ Cartifying Ph	ysician: To the best o				ime date and place				as stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	edical			iner: On the basis of and manner sta	examinati							
		Σ	29b. Signature and ti		Moram	MI.)	29c. Licens	se number	3	29d. Da	te signed (Mor	nth, Day, Year) 2 2009
	3		30. Name and addre	ss of person who o	completed cause of de	eath (Item	23a) (Type,	CLP HIK	1 ST,	BAL	TIM	CRET	MD 21217
	Sta		31. Date filed (Month	n, Day, Year)	32. Registra	r's Signati							
	Registr		APR	2 2 2009) Lewer	1	par	Kal					
DHM	MH 17 Rev 1/2	UU1	• • • •	-	*		19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryland /	/ Depa				iene og. No. 0 0 9	12866
			Decedent's Name (First, Middle, Last)					ate of Death	Day Year	3. Time of Death
	Physicia		BERTHA	1	7	MALON,	4		20 2009	5:13 PM
3	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Loc	ation of Death		4c. County of Death	
	LX	.	Bon Secour			Baltin				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last			Under 24 Hrs. 8, C	Date of Birth Month, Day,	Year) 9. Birthi	place (State or Foreign ntry)
	Director		214-32-1911	M 212 F 78	Yrs.			8/23/	1930 Mich	nigan
	pu ,	-	Usual Residence of Decedent 10a, State 10b. County	10c. City, To	own or Los	cation				10d. Inside City Limits
	ath with the Marylar s 23e or 28e-f show wat be notified at	5				more				1 XYes 2 □ No
	Ba-f	Director	MD	D	alli	10f, Zip Code		10	0g. Citizen of What Cou	ntry?
	vith ti	Dir	10e. Street and Number			21217			USA	•
	s 23s	Funeral	2575 Francis S	t . 2. Was Decedent Ever in U.S.	13 V		nic Origin? (Specify	Yes or No-	14. Race - Ameri	can Indian,
	er de Item	nu	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?	10.	Vas Decedent of Hispa f Yes, specify Cuban, M	lexican, Puerto Rica	n, etc.)	Black, White,	etc.
36	rs aft	by F	3€ Widowed 4 Divorced	If Yes, Give Year or Dates:	1	l□Yes 2⊠No S	pecify:		Specify: B1 a	ack
ò	within 72 hours after death with the Maryland ene. than "natural", or tlems 23a or 28a-f show ta Medical Exeminer raset to molified at	ed	15. Decedent's Educ		6a. Deced	lent's Usual Occupation kind of work done durin	n most of working		16b. Kind of Business/In	ndustry
715	In an	ble	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	`life. L	OO NOT use retired)	ig most of working		D	_
212	d with	Completed	10th		Hom	ie Maker			Domesti	
Maryland 21215-0036	should be filed within 72 hours after dea nd Mental Hygiene. marked other than "natural", or liems imatic event, I've Medical Examinatina	Be	17. Father's Name (First, Middle, Last) U	n k		18.	. Mother's Name (Fil	rst, Middle, M	Maiden Sumame)	unk
<u>a</u>		2								
ary	2 sho and h is ma	. 8	19a. Informant's Name/Relationship (Typ	e, Print)		-			, City or Town, State, Zi	o Code)
	rt 2		Bobby Malone/	Son					, MD, 21217	C
Baltimore,	00 0		20a. Method of Disposition 1 ②Burial 2 □ Cremation 3 □ Re	20b. Place ceme	e of Dispo etery, cren	sition (Name of natory or other place)	Date		20c. Location - City or T	own, State
Ĕ	Page nent o ant: If ury or		' 4 ☐ Donation 5 ☐ Other (Specify)	Mt.	Zior	Cemeter	y 104/28/	09	Lansdowne	, MD
a	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service License	е					neral Hom	
m	82589		Sumerla Ja	nes					o.,MD,212	1 7 Approximate
3C092	Fry Medical Examiner portion and portion and portion and portion as portion as portion as the contract of the	cal Examiner	23a. Part1. Enter the disease, or complications, content failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer Due to (or as a consequer CIRENIC Due to (or as a consequer ARTERIOSE Due to (or as a consequer	MO! nce of): 0:3: nce of):	V/4				Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 moths? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3□	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	Day Year
	quires that the signed by I	ed by P	Part II. Other significant conditions con	tributing to death but not resulti	ing in the u	nderlying cause given i	n Part I.		bacco use contribute to es 2 □ No 3 □ Pro	
00	ıw raquiri s baan si should l	ete	MALNUTE	RITION				24a. Was a	an 24b. Were aut	lopsy findings available ompletion of cause of
Re	he ta e ha age 2	E	HYPERT					perfor	med? death? 2 ☑ No 1 ☐ Yes	2□ No
ta	an:] tifical tor, p	BeC	25. Was case referred to medical	2147701		26	6. Place of Death (C			
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 npatient 2 EF	R/Outpatier	nt 3 DOA Other:	4 Nursing Home	5 Resid	ence 6 □Other (Spec	ity)
on of	Attending Phy r death. ector: After thi by the funeral to		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	f 28c. Injury at Work?			ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st	reet, factory, office	28f.	Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	e Hospita 24 hours e Funera etely fille	edicai C	29a. Certifier 1 Certifying Physical Check only 2 Medical Exemination	sician: To the best of my knowled ner: On the basis of examination and manner stated.	edge, deat on and/or in	h occurred at the time, vestigation, in my opini	date and place, and ion, death occurred a	due to the cat the time, c	ause(s) and manner as date and place, and due	stated. to the cause(s)
	omple	Me	29b. Signature and title of certifier	2000		29c. License n	umber	2	29d. Date signed (Month	n, Day, Year)
	F > F 0	1	-	MAYAM	-,MA	D 2	23300		APRIL 20	2009
	0		30. Name and address of person who co	impleted cause of death (Item 2	23a) (Type	Print) BON	SE2011	RSI	HOSP.	
	4		30. Name and address of person who co	PATEL 2	000	W. 13ALT	D.ST 1	3A2T	0, MD 2	1223
	St Regist	ate rar	31. Date filed (Month Par Yar) 2 2 20	32. Jegistrar's Signatur	1 . A	have				

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i	6	0	0	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible AMEND TTEM 1 per FH G890 4/22/09 WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Dorothy Mohler Dorothy Rigg Mohler Year Month **Physician** 19,2009 11:00P M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville 301 Montrose Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M 2 XF 220-44-2805 12-1-1904 Director 104 PA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits 10a State 28a-f show "natural", or items 23a or 28a-f shov dicel Exeminer mast be notified at ty∑Yes 2 □ No Director Catonsville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 21228 301 Montrose Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mazie Virginia Geyer Samuel Baum Rigg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau once. 1113 Vinyard Hill Road, CatonsvilleMD 21228 Sally Norton - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-23-09 Baltimore, MD New Cathedral 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Fu PA, 2134 Willow Spring Rd, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Demen SYRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Ye a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an perform 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check onl ne) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 2 2009

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keni Williams 1120 N. Kulling Rd Bretimm mD 21728

D33448 April.

1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Modical Examinar must be notified at altimore, Maryland 21215-0036 nd Mental Hygiene. marked other than Health and Nem 27 is man Pages ₽

Physician /Medical

Examiner

10a. State

20a. Method of Disposition

1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

|MD|

Director

Funeral

2

Completed

Funeral

Director

show

death with the Maryland

Physician /Medical Examiner

attending physician and for use as the burial-transit Records, P.O. Box 68760, certificate has been signed by the rector, page 2 should be detached Division of Vital Hospital or Attending Physician: funeral director. After this within 24 hours a er death.

To the Funeral Director: A
completely filled in by the for

Examine Physician/Medical Be Completed by Certification: To

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 2 0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural
2 Accident 5 ☐ Pending investigation 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

(Check only one)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 🗆 Ectopic pregnancy 5 Other (specify)

28b. Time of Injury

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crem.

Day

23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 1 Yes

23d. Date of delivery

20c. Location - City or Town, State

4/18/2009 Beltsville, MD

22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A

Green Pastures Dr. Towson, MD, 21286

24a. Was an perform 1 ☐ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

and manner stated. 29b. Signature and title of certifier

D50040

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

claudia kroker

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of State Registrar	Maryland / Dep	artment of F			giene	12869
	Physici /Medi		1. Decedent's Name (First, Middle, Last)		AUNES		2. Date of Dea	to to to	3. Time of Death 20:50 PM
	Examir		4a. Facility Name (If not institution, give street and number The Johns Hopkins Hospital	ar) -	4b. City, Town, o Baltimore	r Location of Death		4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 □ F 7.	Age (In yrs. last birthday) 89 Yrs.			8. Date of Birth (Month, Day OCT. 1	h 0 Rin	inplace (State or Foreign untry) MD •
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County MD • BALTIMORE	10c. City, Town or Lo	ocation ESSEX				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-f	Director	10e. Street and Number		10f. Zip-Code			10g. Citizen of What Co	
	ath with		2223 PARK DRIVE			21221		UNITED STAT	•
39	be fled within 72 hours after death with the Maryland tal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☐ Married 12. Was Decede Armed Force 12. Was Decede Armed Force 13. Widowed 4 □ Divorced 14. Widowed 4 □ Divorced	es? □ № 1942 -	Was Decedent of Hard If Yes, specify Cuba	Hispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, White Specify:	
215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Business	/Industry
2	filed with Hygiene. other than		8 0 17. Father's Name (First, Middle, Last)	. PR	INTING PR			BETHLEHEM Maiden Surname)	STEEL
/Jan	eve at a be	To Be	FRANCES MAUNES				OWICKI		
Mar	ss 1 and 2 should of Health and Meni item 27 is marker other traumatic e		19a. Informant's Name/Relationship (Type. Print) IRENE MAUNES/WIFE	1	ing Address (Street			er, City or Town, State, 2 MARYLAND	Zip Code) 21221
oore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta		ematory or other plac		Date	20c. Location - City or	
	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	• 2		ess of Facility CH		BALTIMORE, . ZEILER & RE, MARYLAN	SON, INC.
			23a. part 1. Inter the dicease, inconstillications that cau						Approximate Interval Between
	hysician /Medical		Immediate Cause (Final disease or condition a. Mult	iorgan failu					Onset and Death
	Examiner		S. C. S.	as a sequence of):					
	sit	Examiner	if any, leading to immediate Due to (or	as a consequence of): ular neart	distance				
	ate be executed nysician and the burial-transit		that initiated events c.	as a consequence of):	uisense				
3760	cate be ohysicia the bu	edical	d						
. Box 68	that the death certificate be executed do by the attending physician and detached for use as the burial-transit	Physician/Me		h 2 Fetal death 3 tat time of death 5	☐ Ectopic pregnand	ÿ		23d. Date of del Month	ivery Day Year
л. О	requires that the een signed by th hould be detach		Part II. Other significant conditions contributing to deal		underlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ecords,	w requires that been signed to should be de	ted by		•			1 □ Y	′es 2 No 3 □ Pr	obably 4 🗌 Unknown
H Kec	ine iaw ate has b page 2 s	Completed		•			24a. Was a autop: perfor 1 \(\subseteq \text{ Yes} \)	sv prior to	itopsy findings available completion of cause of 2 \square No
\ \Itai	Fnysician: 17 this certificate rral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 = ER/Outpatie	nt 3 DOA Oth	Or:	th (Check only or	ne) lence 6 \square Other (Spec	nif ()
ion of	naing Pny ath. : After this ie funeral c	ation: To	27. Manner of Death 28a. Date of		of 28c. Injur Wor	y at		low injury occurred	му
DIVISION	pital or Attending Fours after death. eral Director: After tilled in by the funer	Certification:	4 Homicide Getermined building	injury - At home, farm, st., etc. (Specify)			City or Town		
1	io the Hospital within 24 hours a To the Funeral D completely filled	Medical	29a. Certifier (check only one) 1 **Certifying Physician: To the besign and manner of the design and the	s of examination and/or ir	th occurred at the time the time the time of t	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manner as date and place, and du	s stated. e to the cause(s)
	Notith To t	Σ	29b. Signature and title of certifier Mulliman M	ID.	29c. Licens	e number	2	April 17 2	
_			30. Name and address of person who completed cause April Villamayor MI		, Print)	600	North Wo	lfe St, Baltimo	ore, MD, 21287
	Sta Registr	ILG.	31. Date filed (Month, Day, Year) 22. Regi	strar's Signature	Ke !				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 8:55 P M Martha Dianna Orlando 17 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Richey Hospice Joseph If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2/22/1930 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F 78 213-26-2517 Maryland Director Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Mydical Evant out the morth of any injury or other traumatic event, the "Mydical Evant" out the morth of any once. 10a. State 1 XYes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21218 702 E. 33rd Street Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 [∑]
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena TIh 1 Anthon Uhl ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 E. 33rd Street, Baltimore, MD 21218 Patricia Orlando/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/2009 Hanover, Maryland Anatany Gifts Registry 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** End-Stage disease or condition resulting in death) dementin (likel /Medical Due to (or as a consequence of): Examiner confication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) (Preson resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Yea 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 5/0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐Yes 2 No 2 No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ð After thi funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) .18.2009 Do41476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYNOND W. WILSON 565 CHARLES N 596 416 31. Date filed (Month, Day, Year) Registrar's Signat Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 10:50 AM Dennis Parker 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Sq uare Kusedale Baltimore ptiacot enter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday, Months Days 1⊠M 2□ F 212-28-9104 82 July 4,1926 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Balto. White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5605 Gunpowder 21162 USA Road 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1944–1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Parker Annie Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Parker 5605 Gunpowder Rd. White Marsh, Md. 21162 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdns. 4-21-2009 BelAir, Md. 22. Name and Address of Facility Schimunek Funeral HOme 21. Signature of Funeral Service Licensee 9705 Belair Rd. NOttingham, Md. 21236 a.l 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or, as a consequence of): +ulmonar Aema Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ivac man Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 ☐ Yes

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau

Physician

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Event man be notified at

1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. em 27 is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

10a. State

Md.

Director

Funeral

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Completed

Be

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requires that the death certificate be executed sician and burial-trans attending physician as the for use signed by the a been

Box 68760,

P.0.

Division of Vital Records,

certificate has page 2

Physician/Medical IF FEMALE: þ Completed Be

Examine Certification: To After this funeral

or Attending Physician: after death. eral Director: A To the Hospital within 24 hours a

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 ANo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 062373

State Registrar

Medical

Kobert taz 31. Date filed (Month, Day, Year) -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklind

ave,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 9:22 Rebecca Pierce 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 X F Months Feb. 1914 95 Director 121-16-1747 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, I'm Natical Exercitation profiled at 1 XYes 2 ☐ No Director Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 10102 Kathleen Drive 20744 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No δ Specify: 3 X Widowed 4 □ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Work Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (John Henry Coston Sally Boone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya Gary (Niece) 10102 Kethleen Dr., Ft. Washington, MD 20744 Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Canaan Baptist 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation Suffolk, VA 5 ☐ Other (Specify) 4/25/09 Church Cemetery 22. Name and Address of Facility
Crocker Funeral Home 21. Signature of Juneral Service License 900 E. Washington St., Suffolk, VA Mann 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL /Medical Due to (or as a consequence of) Examiner ASTHMA Sequentially list conditions, if a.iy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine RES PIRATORY INSUFFICENCE burial-trar Due to (or as a consequence of): Physician/Medical PEMUR use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy forι in the past 12 months Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 2 ASTHMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed ENEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 No SYN DROME SICK SINUS 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To

P.O. Box 68760, attending physician certificate be detached Records, cate has been signated by page 2 should b Division of Vital ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th

with 1

death v

72 hours after

Maryland 21215-0036

Baltimore,

Pages 1

27. Manner of Death

29b. Signature and title of certifier

1
Natural

Accident

5 Pending investigation 6 □ Could not be

28a. Date of Injury (Month, Day, Year) -31-09

and manner stated.

28b. Time of Injury 28c. Injury at Work? 0800 A.M. 1 ☐ Yes 2 XXX 28d. Describe how injury occurred

Fell white walking unassisted.
281. Location (Street and Number or Rural Route Number, City or Town, State)

4/16/09

3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide VILLA ROSA ASSISTED LIVING Home 3800 Lotts food Vista RI, Bowie M.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20121

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

3800 Lotts ford Vista RI, Bowie, MD

29d. Date signed (Month, Day, Year) 29c. License number

1005095 1

Name and address of person who completed cause of death (Item 23a) (Type, Print)

REVA.S. GILL, 6510 KENILWORTH AVG SUITE 2400 RIVERDALE MODERT

State Registrar

filled in by the

To the Hosp within 24 hor To the Fune completely fi

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of I	Maryland	-	artment c				Reg. No.	2009	12873
	Physici	an	Decedent's Name (First, Middle, La.							2. Date of De Month	aath Day	Year	3. Time of Death
	/Medi		Catherine Phi	-						April		2009	8:55P M
	Examir	ner	4a. Facility Name (If not institution, give				4b. City, Tov	vn, or Location	on of Death		4c.	County of Death	1
			Transition He				Syke:	svill	e der 24 Hrs.	0 D-11 Di-		Carrol	
	Funeral		5. Social Security Number 6. S	DM XTE	Age (In yrs. Ia	ist birthday) Yrs.		ays Hou		8. Date of Bir (Month, Da	ay, Year)		place (State or Foreign intry)
	Director		218-10-9897 Usual Residence of Decedent		90					4-13-	1919)	MD
	land M		10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Inside City Limits
	Marylan f ehow	JO.	MD Carrol	1	Svk	kesvi	116						1 ☐ Yes 2 ☑ No
	28a	rec	10e, Street and Number	-	1 21-	10011	10f. Zip Co	de			10g. Citi	zen of What Cou	intry?
	with Sa or	Funeral Director	2810 Kaywood	01200				21784					•
\	leath na 2	era	11. Marital Status	12. Was Decede	ent Ever in U.S	6. 13.1				ecify Yes or No Rican, etc.)	US -	A 14. Race - Amer	ican Indian,
10	ffer of	Fu	1 ☐ Never Married 2 ☐ Married	Armed Force						Rican, etc.)	1	Black, White	
38	ol', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 ☐	MNo Spec	city:			Specify: Wh	ite
21215-0036	72 hours affer death with the Maryland naturel', or Itema 23a or 28a-1 ehow disal Examinet must be mutified at	Completed	15. Decedent's Ed	ducation		16a. Dece	ient's Usual O	ccupation			16b. Ki	nd ol Business/li	ndustry
218	within 7 ene. than "n	ple	(Specify only highest gra	College (1-4	or 5+)	life.	kind of work d OO NOT use n	etired)	TIOST OF WOR	ang			
21	d wit	NO.	12			R	ookko	nor			Fir	ancial	
b	e file al Hy oth	Be (17. Father's Name (First, Middle, Last,				00717100	18. M	other's Nam	e (First, Middle	, Maiden	Sumame)	
<u> a</u>	s should be filed within and Mental Hygiene. s marked other than "	10E	John Koutch							eth Gel			
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (St	treet and Nu	mber or Rui	al Route Numb	er, City o	Town, State, Zi	ip Code)
	and 2		Linda Siehler -	- Daught	er	613	Fern	Way.	Syke	svill	e . M	D 2178	А
ore	of He		20a. Method of Disposition	10	CO	ace of Dispo	sition (Name of	of	1	Date	20c. Lo	cation - City or T	own, State
Ĕ	Page nent int: If		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			Law	n Ceme	terv	4_17	7-09	Bal	timore	MIN
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!, or itema 23a or 28a-4 ehow important: if item 27 is marked other than "nature!, or itema 23a or 28a-4 ehow arry injury or other treumatic event, its Mydical Expriner must be notified at Ance.		21. Signatura of Funeral Service Licer	1500			. Name and A		acility				*
œ	Depring on your		Diffill)		D	n 215	A Tal	llow	Coming	ASDO	on Fun	eral Home
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the death.	. Do not ent	er the mode of	f dying, such	as cardiac	or respiratory a	rest,	ad, Zi	proximate Interval Between
	Physician		Immediate Cause (Final	one cause on eac	C	0 . 0							Onset and Death
1	/Medical		disease or condition resulting in death)	a	as a conserv	ence of):							
н	Examiner												
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a conseque	ence of):							
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	0									
Ć	exec in an	Exa	resulting in death) Last	Due to (or	as a conseque	ence ol):							
760,	The law requires that the death certificate be executed the hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ca		d									
68	g phy as th	ed	2.50										
Box 68	andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7=				1 2	23d. Date ol deliv	very
	death e atte d for	ic a	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnan	n 2 ☐ Fetafo t at time of dea]Ect <i>o</i> pic pregn] Other (s <i>pecil</i>					Month	Day Year
P.O.	t the by th ache	hys	9 🗆 Unknown	9□ Unknow	n								
	uires tha signed I id be det	by Physician/Med	Part II. Other significant conditions of	contributing to deat	h but not resul	lting in the u	nderlying caus	e given in Pa	art I.	23e. Did 1	tobacco u	se contribute to	the cause of death?
ğ	quire in sig uld b		1/20	odida	Ula					10	Yes 2	□No 3□Pro	bably 4 Unknown
၀ွ	w re	lete	Den	nen (ie						24a. Was	an	24b. Were aut	opsy findings available
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	in: T		25. Was case referred to medical				-	00 0	toon id Dead	100000000000000000000000000000000000000	2 No	1 ☐ Yes	2 □ No
of Vital	Physician: rthis certifice ral director, i	o Be	examiner?	Hospital:	atient 2 ☐ E	EP/Outpation	* 3□ DOA	Othor		h Check only		S ☐Other (Spec	
of	Phy ir this	To	27. Manney f Death	28a. Date of (Month,		28b. Time of		Injury at Work?	inuising n	28d. Describe			iry)
o	ding th.	후	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio		Day Year)	Injury	М	Work? 1 ☐ Yes 2	2 🗆 No				
Division	Attending r death. ector; Aflet by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not b	286. Place of	Injury - At hor	me, farm, str	eet, factory, of	ffice		28f. Location (Street an	d Number or Rui	ral Route Number,
Ö	after Olre	ert	4 Homicide	building	, etc. (Specity))				City or To	wn, State)	
	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director, After this certificete hes been si completely filled in by the funeral director, page 2 should	2	29a. Certifier 1 Certifying Ph	nysician: To the be	est ol my know	vledge, deat	n occurred at t	he time, date	e and place.	and due to the	cause(s)	and manner as	stated.
	24 h 24 h Fui etely	Medical	(Check only 2 Medical Examone)	niner: On the basi and manne	s of examination	on and/or in	vestigation, in	my opinion,	death occur	red at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the comple	ĕ.	29b. Signature and title of certifier			/	29c. Li	icense numb	per		29d. Dat	e signed (Month	, Day, Year)
	-> - o				\ /		0	0050	163		4	1519	
			30. Name and address of person who	completed cause	of death frem	23a) (Type	Print)	-	I N -	^		/ - 1/	
			8 26 (Nooh	2000	20	(,)	200	in her	m	d. 7	115	7	
	St	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signati	ure ,	and the	y - 0 -	* 1			1	
	Regist		APR 2 2 2	109 /2	of death fitem	1. 4	arke						

DHMH 17 Rev 1/2001

09-03015 Michael Peeling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 12874

		- For State Registrar	,	Certific	ate of Dea	ath		Reg	J. No.	0 0	7 1 2 0 1
Physician	1/	1. Decedent's Name (First, Middle					2	2. Date of Death Month	Day Vest		3. Time of Death
Medical Examine		Michael Michael	B. Peeli		Lucian	- 1	of Dooth	April 15, 20	09		1005 hrs
	ı	4a. Facility Name (if not institution 116 Butler Road	i, give street and number)		, Town, or Location sterstown	on of Death		4c. County o		nty
Funeral	T	5. Social Security Number	6. Sex 7. Ag	je (In yrs. last bi			Inder 24Hrs.	8. Date of Birth	(MM/DD/YYYY)	Foreign	
Director		214-92=4117	1 X M 2 F	41	Yrs.	iths Days Ho	ours Min.	July 1	7,1967	Cou	ntry) MD
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	or Location					—	10d. Inside City Limits
1			imore								1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number	Imore	I Ke	istersto 10f. z	Zip Code		10	g. Citizen of Wh	at Coun	try?
the M a or 2	5	116 Butler R	oad			21136			USA		
h with	Funeral	11. Marital Status	12. Was Deceden		13. Was Dece	dent of Hispanic cify Cuban, Mexi	Origin? (Spe	ecify Yes or No-	14. Race White		an Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	뒤	1 Never Married 2 Ma 3 Widowed 4 X Divo		X No		2 X No spec		treatily other,			
urs afte	<u></u>	3 Widowed 4 X Dive	or Dates:	mpleted) 16a	. Decedent's Usu			ork done	Specify: 16b. Kind of Bus		ite
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imo Pages ment of tant: I or oth		4 Donation 5 Other Sp		ale	oll Crem	ation	4/2	1/09	Hampste	ead,	MD
Baltimore, MD permit. Pages I and 2 sho Dopartment of Health an important: If tiem 27 is injury or other traumati	Ī	21. Signature of Funeral Service	Licensee	.1/.:	22. Name a	nd Address of Fa	cility 118	24 Reis	terstow	n Ro	ad
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/Medical		failure. List only one cause				,g ,		,	, ,		Between Onset and Death
xaminer	1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		Ticad						
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760, cate be ex physician the burial	Ĕŀ	IF FEMALE:	23c. If yes, outco	me of pregnanc	y				23d. Date of	delivery	
	cian'	23b. Was decedent pregnant in th past 12 months?	I Live Ditui	t time of death	2 Fetal dea 5 Other (S		topic pregnar	icy	Month	D	ay Year
Box death he atte	Physician	1 Yes 2 No 9 Unk			5 Other (S	Decay)					
that the death certifulation of the attending detached for use as	9 2	Part II. Other significant conditi	ons contributing to deat	th but not resulti	ng in the underly	ng cause given i	n Part I.				he cause of death?
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Vital Records, system: The law requirents this certificate has been director, page 2 should	Completed							1 ✓ Yes 2		✓ Yes	s 2 No
ital Recicion: The scerificate rector, page	a Re	25. Was case referred to medical examiner?	Hospital:		D. 4414 D	26.Place of De			2	2 Other	. 0
n of Vi	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death	128a, Date of Ini	urv 28b	Outpatient 3 Time of Injury	DOA Other			Residence 6 v		Scene
Division of Vital Records, P. rater death Physician: The law requires the rater death The rates of the rate of	Certification:	1 Natural 5 Pend	ing FOUND: Day,	Year) FO	UND: 00 hrs	1 Yes 2		Subject shot	self		
Division Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	<u>≅</u>				farm, street, facto	ory, office building	g, etc.			er or Rur	ral Route Number, City
Di pital ours at ours at filled	5	4 Homicide deter		ngle Family	Home		1	or Town, St 16 Butler Ros	ad, Reisterstov	vn, MD	
	edical	Check only	nysician: To the best of miner:On the basis of exa	mination and/or							
To To	ğ	29b. Signature and title of certifie	and manner stated		1	29c. License num	ber	7	29d. Date signe	ed (Mon	ath, Day, Year)
		Carre A	Halla.	\wedge		O.C.M.E.			April 16, 20)09	
O_{r}		30. Name and address of person		` '		Delkies '	MD 04004				
Stat	10	Carol Allan, MD Ass 31. Date filed (Month, Day, Year)	sistant Medical Exa	miner 113 ar's Signature	Penn Street	, baitimore, i	IVID 21201				
Stat Registra	v			6	back	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Deredent's Name (First, Middle 3. Time of Death 2. Date of Death Year **Physician** 2156 PM ueen 10/1 009 /Medical 4c. County of Death dity Name (If not institution, give street Sitv>Town, ar Location of Death Examiner Kmor: If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. Month, Day, LIV July timo re 7. Age (In yrs last birthday, Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 1and Director Usual Residence of Decedent the Maryland 10h County 10c, City, Town or Location 10d. Inside City Limits show d other then "neturel", or items 23e or 28a-f shovevent, If a Medical Exercities must be notified at Altimore 1 Yes 2 □ No Director 10e. Stre et and Number 10f. Zip Code 10g. Citizen 9 What Country? with death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 15 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel: any injury or other traumatic event Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT ase retired) 16b. Kind of Business/Industry (912) Elementary/Secondary College (1-4or 5+) ustodia ch00 18. Mether's Name (First, Middle Be 2 Number or Rural Route Number, City or Town, State, Zip Code) Name/Relationship Mailing Address (Street and ueen bb ons SAltimore 3 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 0400 gignatury of Funeral Service Licensee Approximate Interval Between Onset and Death Pnysician NKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ur derlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed? res 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 No 2 ER/Outpatient 3M DÒA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

APR 2 2 2009

31. Date filed (Month, Day, Year)

tsaro

32. Registrar's Signature

Union

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** /Medical Name (If not institution, give street and number, or Location of Death **Examiner** D Birthplace (State or Foreign Country)
 M Birth Day, **Funeral** Hours Min. 1 X M 2 □ F 65 218-42-8637 Director 03-04-1944 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2√ No MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3835 Bay Road 21154 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental John William Rife Avery Gilliam ပ Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Belcher (Wife) 3835 Bay Road Street, MD 21154 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 04-21-2009 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence Examiner Se prentially list could be if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and burial-trar Box 68760; physician Physician/Medical law requires that the death certificate the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy certificate 1 ☐ Yes 2 **[27**0 Vital 1 □ Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA Division of this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation the Hospital or Attending death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

2 2 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 5:45 An - 2009 6 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Deeth 4c. County of Death If Under 24 Hrs. 8. Date of Birth Examiner eute 2501 1 nav esc If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign , Funeral Months Days 1⊠M 2□ F 50 Yrs. 9/10/1958 230-96-2192 Virgínia Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other then "natural", or Items 23e or 28e-f showevent, the Medical Exertiner must be notified at MD St. Marys Lexington Park 1⊠ Yes 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. Winding Way 20650 21134 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married l X Yes 2 □ No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Ni Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Crane Rigger 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) cepartment of Heelth and Ment, Important: If Item 27 Is marked eny Injury or other treumatic events. Blanche Jett Randolph Ransone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 133 Creek View Lane, Colonial Beach, VA 22443 Ransone/ Mother Blanche 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/2009 Hanover, Maryland Anatomy Gifts Registry 4 XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deat **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Que to requires that the death certificete be executed ettending physician end for use as the buriel-transit Exami Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last uence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the er Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to tha ceuse of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ۾ been si 24b. Were autopsy findings 24a. Was en autopsy performed? Completed available prior to completion of cause of deeth? certificete has b lirector, page 2 s 2 No 1 Tes 1 ☐ Yes 2 ☐ No director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No. Other:

Aursing Home 5 □ Residence 6 □ Other (Specify) Hospital: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 27. Manner of Deeth Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftert Certification: 5 Pending 1 Yes 2 No death. investigation 2 Accident efter death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide ō within 24 hours e o the Hospita Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 132 registrar's Signatur Amir pmirec

DHMH 16 Rev 6/95

State Registra 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL ELIZABETH REICHEL 11:34 AM 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 □ M 2 🖫 F Days Min 873071924 Pennsylvania 207-14-7065 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Ellicott City 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9145 Winding Way 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12yrs Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio DeLaurentis Maurette DiCola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9145 Winding Way Ellicott City, Md. 21043 Louis W. Reichel/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ardent Crematory Inc. 4/22/2009 Hanover, Md. 22. Name and Address of FacilithHarry H.Witzke's Family F.H.Inc. 21. Signature of Funeral Service Ligensee MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 mals 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE MYOCARDIAL I WEARCTION HOUR disease or condition resulting in death) Due to (or as a consequence of): COROHARY ARTERY DISEASE KENDS Due to (or as a consequence of) HYPERTENSION YEARS Due to (or as a consequence of): DIABETES MELLITUS YEARS 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC KIDNEY DISEASE AMEUMONIA DULLYOUARY 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown EDEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

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certificate has Physician: The

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To the nospressivity within 24 hours after death.

To the Funeral Director: Af

Attending

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law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

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Funeral

Director

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permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

/Medical

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Director

Funeral

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Completed

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Physician/Medical

Completed by

Be

Medical Certification: To

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last JE FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Yes 2 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

(Check only one)

29b. Signature and title of certifier

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28h Time of 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 038296

29d. Date signed (Month, Day, Year) APRIL 21 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8186 LARK BROWNRD, SUITE 201, ELKRIDGE, MD 21075 JOSEPH GIBBONS MD 31. Date filed (Month, Day, Year)

State Registrar

5 ☐ Pending investigation

6 ☐ Could not be

			For State Registrar	State of Maryla		partment of H <i>ertificate of L</i>			giene Reg. No.2	009	12879
	Physicia /Medic		1. Decedent's Name (First, Middle, La BLANCHE K. RAAB	st)				2. Date of Dea Month APRIL	Day 20	2009	3. Time of Death 11:55 \PN
	Examine Funeral		4a. Facility Name (If not institution, given Stella Maris HOS 5. Social Security Number 6.5.	SPICE Sex 7. Age (In)	yrs. last birthda Yrs	Timon	Location of Death LUM If Under 24 Hrs. Hours Min.	8. Date of Birt	ih y, Year)	Cour	place (State or Foreign
	Maryland -f show	tor	234-26-5784 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo		. City, Town or		County	Nov. 1	1,131		0d. Inside City Limits 1 □ Yes 2 💆 No
	ath with the s 23a or 28a	eral Direc	10e. Street and Number 115 Cowhide Circ			10f. Zip Code	21220		U	en of What Coun	
p.m.	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Modicet Examiner must be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	n U.S.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Ispanic Origin? (Spe an, Mexican, Puerto F Specify:	Rican, etc.)	s	I. Race - Americ Black, White, e Specify: Whit	etc. Çe
11:55 p.m 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan togs 1 and 2 should be filed within 72 hours after death with Mental Hygiene. If If Hem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be recilified at	Completed by Funeral Director	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 yrs.	control contro	(G.	cedent's Usual Occup ive kind of work done of b. DO NOT use retired Dector=Qua	during most of working) lity Conta	rol	Mart	of Business/Ind	dustry
, 2009 Maryland	should be filed and Mental Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last Lesle E. Kennison 19a. Informant's Name/Relationship	on	19h M	ailing Address (Street	18. Mother's Name Louise	Cheek			a Cade)
20 Fe.	es 1 and 2 si of Health an filtem 27 is i		JoAnne Spangler 20a. Method of Disposition XXI Burial 2 Cremation 3 C	(Daughter)	81	6 Oakleigh sposition (Name of rematory or other place	Beach Rd		more,		L222
APRIL 20 Baltimore.	rmit. Pa partmer portant: y Injury ce.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	(y)	Parkwo	od Cemeter 22. Name and Addres Lassahn 7401 801		ome		cimore,	
4	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the	ANCER					3. 21200	Approximate Interval Between Onset and Death
68760	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con							
RAAB	attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23	3d. Date of delive Month	ery Day Year
BLANCHE 1	w requires that the dispersion is been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not	t resulting in the	e underlying cause giv	en in Part I.	23e. Did t			he cause of death?
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Division of Vital	eath. or: After he funera	ertification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not to determine determined.	e 280 Place of Injury	28b. Tim Injur	e of 28c. Injur y Worl M 1 🗆	er: 4 Nursing Hor ry at k? Yes 2 No	me 5 Resi	dence 6	occurred	fy) HOSPICE
į	Hospita 4 hours Funeral tely filled	Medical Cert	29a. Certifier 1 ☐ CertifyIng P	hysician: To the best of my miner: On the basis of exa	knowledge, d	eath occurred at the ti r investigation, in my c	me, date and place, opinion, death occurr	and due to the	cause(s) a	and manner as solace, and due to	stated. o the cause(s)
	To the I within 2 To the Comple	Mec	29b. Signature and title of certifier	UNP		29c. Licens	19792		29d. Date	signed (Month,	Day, Year)
	8		30. Name and diddress of person who JACKIE JONES, CR 31. Date filed (Month, Day, Year)		ANEY VA		TIMONIUM,	MD 210	193		
	Sta Registr		APR 2 2 2009	Peners &		d)					

DHMH 17 Rev 1/2001

APRIL 20, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 7:25 a. April 16, Wilfred Herzer Romme1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Potomac Valley Nursing & Wellness Cntr. Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 M 2 F Director 93 March 6, 1916 North Dakota Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral', or items 23a or 28a-f shov Examiner must be notified at DC 1 X Yes 2 No Washington, DC Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4301 Massachusetts Ave., N.W., #6013 20016 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. Amied Poices: 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: À 3 XWidowed 4 □ Divorced natural Completed The Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Legislative Analyst Federal Government 12 5+ other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Rommel Winnifred Herzer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sitment of Health an tant: If item 27 is a (granddaughter) 1285 Terrace Ln. Arnold, Maryland 21012 Shelley Gallagher 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 20, 2009 1 ☐ Burial 2 ACremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Gervice Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final duauc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burialof Vital Records, P.O. Box 68760, Physician/Medical **tF FEMALE** 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 10 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the t 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLUD MENDT 31. Date filed (Month, Day, Year) = 32. Resistrar's Signature State Registrar

Physician

Examiner

Funeral

Director

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 10:50 P^M Margaret Kathleen Rolph Apri1 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Timonium der 1 Year | If Under 24 Hrs. Baltimore <u>Stella Maris</u> 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 1 □ M 2 🗷 F 1/28/192 Ireland 563-82-5850 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐Yes 2 X No MD Baltimore <u>Lutherville</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 37 Wandsworth Bridge Way 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify Specify: 3 Midowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Henderson Angelina Horton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Limerick Circle Timonium, Maryland 21093 Mr. John Rolph / Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cypress View Memorial 4/24/09 San Diego, California 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Con 23a. Part 1. Enter the disease, or conshock, or heart failure. List Approximate Interval Between Onset and Death pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2X No 3 Probably 4 Unknown

Examine the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached 2 Completed Be Certification: To s after decreal Director: Aft filled in by

									24a. Was an autopsy performed? 1 □Yes 2 X No	prior to con death?	osy findings available npletion of cause of
25. Was case refer	red to medical						26. Place of Dea	ath (C	Check only one)		
examiner? 1 ☐ Yes 2 K	No	Hospita	l: 1 ☐ Inpatient 2 ☐] ER/Outpatient	3 🗆 [DOA	Other: 4 I Nursing H	lome	5 ☐ Residence 6	X Other (Specify	HOSPICE
27. Manner of Deat 1 Natural 2 Accident	5 Pending investigation	1	. Date of Injury (Month, Day, Year)	28b. Time of Injury	М		Injury at Work? 1 □Yes 2 □ No	280	I. Describe how injury	occurred /	
3 ☐ Suicide 4 ☐ Homicide	6	28e	. Place of Injury - At h building, etc. <i>(Spe</i> c	ome, farm, stree	et, facto	ry, off	fice	28f.	Location (Street and City or Town, State)	d Number or Rura	Route Number,
29a. Certifier (Check only							the time, date and place my opinion, death occu				

oneX Nurse Practitionerner stated.

29c. License numbe

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) 32

Registrar's Signature

within 24 hours a

Medical

State Registrar 29b. Signature and tight

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Mary	-	artment of H			giene Reg. No.	12882
_	-	Registrar 1. Decedent's Name (First, Middle, Las	st)		inoato or E		2. Date of Dea	ıth	3. Time of Death
Physicia		Arley Ha	arriet Schu	1er			Month April	18, 2009	11:11A M
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	119	4c. County of Dea	
xammi		1840 Eagle Court			Se	vern		Anne Ar	unde1
Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h 9. Bir	thplace (State or Foreign
Director		468-22-5820	□M 2 🖫 F 9	3 Yrs.	Wioriting Days	Trodio Willing	02-14-1		nnesota
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aryla sho	j.			2. Oity, Town of Lo					1 □Yes 217 No
the M	Director	MD Anne A1 10e. Street and Number	rundel		Sev 10f. Zip Code	ern		10g. Citizen of What Co	
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rtme rtant njury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Methodis	st Cemeter 2. Name and Addres		4-2009	Madison, N	linnesota
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be notified at once.		21. Signature of Fulleral Wide Licen	Eluxel	is "	Donaldsor	n Funeral	Home & ad Oden	Crematory, ton, Maryla	P.A. and 21113
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tend leath. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2□No			
or Al	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	еет, тастогу, опісе		City or Tow	Street and Number or Fi n, State)	urai Houte Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	ane)	niner: On the basis of exa and manner stated.	amination and/or in					
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1			completed cause of death	(Item 23a) (Type,	Print) ada f	ank Dr	me be	O Burnit	, md 2106/
Sta		31. Date filed (Month, Day, Year)	3. Registrar's S	Signature	del.		7		
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS G891.5/11/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mattie Swinton Month Pu **Physician** 2000 /Medical 4b. City, Town, or Location of Death Bolain Rd. Balling 4a. Facility Name (If not institution, give street and number) County of Death Examiner Belair Rd. Nurseng Gariner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2□ F Months Days Hours Min 213-20-4863 90 **Director** OCT 27 1919 5.C Usual Residence of Decedent filed within 72 hours after death with the Maryland Show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In Medical Examinar must be notified. 1 ☐Yes 2 ☐ No Director MD Timone 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA ELAIR RD 21239 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BLACK þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Smy Day 79 RAINE 5 ChOOL BALLO CITY Ublic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WAL ည Cnr4 NICEY WOODS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KHEA 503 BALTO mo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-15-09 4 ☐ Donation 5 ☐ Other (Specify) RBUTUS MEM PAKE ARBOTUS MID 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ARRICA Bette CAROLING Mid BALTO 21213 51 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Duy to (Examiner helea Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 C Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? certificate 2 00 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Near) 29b. Signature and title of Gertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

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6 ☐ Could not be determined	Zoe. Flace Ul III	ury - At home, far c. <i>(Specify)</i>	m, street, factory	y, office	28	8f. Location (City or To			ural Route Number,
			1			-11			
	nysician: To the best niner: On the basis of and manner st	of examination and							
itle of certifier			29	c. License number			29d. D	ate signed (Mont	h, Day, Year)
uaaa	Soos	e mo	I	00605	32		0	4-21-	09.
ss of person who	completed cause of	death (Item 23a) (_	4				
RAAB	SOOK		. 19	Walne	IL	ane	A	Sudee	n-mo.
h, Day, Year) 2 2 2009	82. Regist	rar's Signature	arked						
			RIGINAL						
			, 11-0111 1/ No						

Division of Vital Records, P.O. or Attending Within 24 hours after death.

To the Funeral Director: Af

To the Hospital

Be

Certification: To

Medical

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HNURAA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Dept 1 - State Registrar Ce	rtificate of Death	, ,	eg. No. 2009 12885
	Dhuaisic		1. Decedent's Name (First, Middle, Last)		Date of Death Month	
	Physicia /Medic	al	Keith Lamon Sheckles		Apr 8,	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Harford
agent of the			6. Sex 7. Age (In yrs. last birthday)	Havre de Grace		
	Funeral Director		215-46-7316 1⊠M 2□F 59 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, JUL 9,	1949 North Carolina
	w and	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	/lary	5	Maryland Harford Havre	de Grace		1 □Yes 2 √ No
	28a-	Director	10e. Street and Number	10f. Zip Code	10	Dg. Citizen of What Country?
	3a ol		625 Hoppers Lane	21078		United States
20	should be filed within 72 hours after death with the Maryland and Mental Hyglene. Marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show imatic event, Ite Modies! Examines must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ ▼	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
3	hour Itural	edk	15 Decedent's Education 16a, Dece	edent's Usual Occupation	1	16b. Kind of Business/Industry
<u> </u>	nin 72 in "ing in "ing	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	ing	Building Construction
7 7	d with giene er tha	E O	Elementary/Secondary (0-12) College (1-4or 5+) Car	penter		Construction
		Be (17. Father's Name (First, Middle, Last)	18. Mother's Name		· · · · · · · · · · · · · · · · · · ·
Na Na	Ment Ment arked atic e	2	Bobby Lamon Sheckles	Doret	hea Medf	ord
Maryland 21213-0036	permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic even once.			ing Address <i>(Street and Number or Rur</i> Hoppers Ln., Havr		
ē,	star fHee item othe		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Imatory or other place)	Date 2	20c. Location - City or Town, State
Ē	Page ent o nt: If ry or			Services Univ 4/9/	2009	Bethesda, MD
saltimore,	ermit. Pepartn nporta ny inju			2. Name and Address of Facility Rapp Funeral & Cre		Services
	20 = @ O		23a, Part 1. Enter the disease, or complications that caused the death. Do not en	933 Gist Ave., Sil	ver Spri	ing, MD 20910 est. Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	11 Can como ma	C 10	Inferval Between Onset and Death
	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	gratic fly	L Can	COY
68/60,	cate be physicia the bur	edical	d			
×	oer din se	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
7.	s that med by e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
ğ	w requires t s been signe should be	ed t	1 type lensian		1 ☐ Ye	es 2 No 3 Probably 4 Unknown
Il Records,	The la	Completed			24a. Was ar autops perform 1 □ Yes 2	y prior to completion of cause of
N II	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	and the same of th	h (Check only one	·
Division of Vital	for the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	ıtion: To	1 Yes 2 No Tospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Date of Inj	of 28c. Injury at Work? M 1 □ Yes 2 □ No		ence 6 ☐ Other (Specify) ow injury occurred
DIVISI	tal or Atter rs after dea al Director led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occur	, and due to the cared at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
	,		71.00	030313		7113/007
	4		30. Name and address of person who completed cause of death (Item 23a) (Type		a Caro.	4/15/2009 Howdogness Md21.78
	Sta Registr		31. Date filed (Month, Day, Year) 32. Prigistrar's Signature	backer		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Springs 18:30 M Eugene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boltimore N/A ohns Hopkins BRYVICU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 17, 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 **X**M 2□ F Months Hours Min. WEST VIRGINIA 213-26-9195 77 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3235 CLIFTMONT AVENUE 21213 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes X No If Yes, Give Year or Dates: Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. M. College (1-4or 5+) MACHINIST TOOL CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GARNETT **JAMES SPRIGGS** LACY McCROSKY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY J. SPRIGGS/DAUGHTER 8005 MIDHAVEN ROAD, DUNDALK, MARYLAND 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. CARMEL CEMETERY 4/24/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 2. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Endolarditis /Medical Due to (or as a consequence of): Right PLA STroLe Examiner MICA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and Due to (or as a consequence of) burial Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the signed by to be detach Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No as s page certificate 2 🗆 No 1 ☐ Yes 1 Yes To the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation within 24 hours after voc...

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar

BAYVIEW

32. Registrar's Signature

RES-00 19

((INDA HOBULA, MD)

Mebule

HOPK

APR 22 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINda

JOHNS 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:20 AM need 9, 2009 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Street If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, 1930) 10-30-1930 Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months Hours 212-12-751 Director Usual Residence of Decedent filed within 72 hours after death with the Marylanc 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 'natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, fire Medical Examiner must be rediffed at once. Baltimore 1 es 2 No Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 310 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. 20 NOT use retired) (Specify Elementary/Secondary (0-12) College (1-4or 5+) ee First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ပ imeon Informant's Name/Relationship (Type. Print) (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Balto. MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State lowson 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee odit Greene Funeral Services Baito. Nat'l Pile (21229) 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a commune of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to jor as a consequence of: death certificate be executed Due to (or as a consequence of) 68760, signed by the attending physician Be Completed by Physician/Medical use as the Box IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to beath but not resulting in the underlying cause given in Part I. Records, No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy or Attending Physician: The **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 \sum Nursing Home , 5 Residence 6 ☐ Other (Specify) Medical Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) ross of person who completed cause State Registrar

DHMH 17 Rev 1/2001

12888

		•	1 - For State State Of Maryland / L	•	tificate of l			Reg. No.		
	Physicia /Medic		1. Decadent's Name (First, Middle, Last) Danueld M Thomey				2. Date of Dea Month	Day	Year	3. Time of Death
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Parkvi.	Location of Death	`		nty of Death timore	
Ė	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	rthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month_Day 05-25-	h	0 Rinth	place (State or Foreign
		Director	Usual Residence of Decedent 10a. State					10g. Citizen		IOd. Inside City Limits 1 □Yes 2 No
036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atte event, If a Madical Examinar must be netified at	by Funeral	8800 Walther Blvd Apt 4006 11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:		2123 Vas Decedent of H f Yes, specify Cuba □ Yes 2 No	4 lispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	i	Race - Ameri Black, White, ecify: Wh:	etc.
21215-0036	d within 72 horgiene. er than "natur er than "natur	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. [dent's Usual Occup kind of work done of DO NOT use retired utive VP	during most of worki		Stone	f Business/In	
land	should be filed withir nd Mental Hygiene. marked other than imatic event, It o M	To Be (17. Father's Name (First, Middle, Last) Clarence Thomey			18. Mother's Name Anna Don		Maiden Surr	name)	
Mary	nd 2 shoualth and Market and Market Is ma					and Number or Run Blvd Pa				
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic es <u>once</u> .		4 □ Donation 5 □ Other (Specify) Bel A:	ir M	sition (Name of natory or other place	04-24		Bel Ai		
Ba	permii Depar Impor any in		21. Signature of Funeral Service Licensee	In	. Name and Addres	· MacPhai	imunek 1 Rd Be	Funera 1 Air,	1 Home MD 2	e of BelAir 1014
	Cate be executed / Medical Examiner and the purial-transit the purial-transit	Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence) C. Due to (or as a consequence consequence)	of):		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
O. Box 6	eath certif attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnanc Other (specify)	у		23d.	Date of delive	rery Day Year
ds, P.	w requires that the described by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in	n the ur	nderlying cause giv	en in Part I.				the cause of death?
Vital Records,	sician: The law rec s certificate has bee lirector, page 2 shou	e Completed	6D bleed my 25. Was case referred to medical			26. Place of Deat	1 □ Yes	2 No	4b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
Division of Vi	ling Phy I. After this uneral d	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	utpatien Time of Injury	28c. Injur Worl	er: 4 Nersing Ho	ome 5 Resid	dence 6 🗆		ify)
Divis	al or Attends after death	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location (5 City or Tox	Street and Nu vn, State)	umber or Rur	al Route Number,
)	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in the complete of the comple	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination a and manner stated.							
	To the vithin comp	M	29b. Signature and title of certifier	للا	29c. Licens	e number	02	29d. Date sig	gned (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 21a)	(Type,	po w	Ether B	(0)	Parll	mlle	Marray
	Sta Registr		31. Date filed (Month, Day, Year) — 32. Registrate Signature	1	hadel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09:16 A M HARLIE APRIL 2000 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE Smal HOSPITAL OF BALTIMOKE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Days 1**⋈** M 2□ F 241-64-3304 FEB. 16, 1938 N. CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number AGNES LANE, APT. 5.14. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ✓ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTICICAL MACHINIST 7TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THORNE HARRISON CHARLIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3816 GREENMOUNT AVE. BALTO, MD 21218 ANNETTE BROCKS (DAVGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRPMATORY :04-21-2009 BACTIMORE, MARYLAND METRO 22. Name and Address of Facility 50SEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee istich N. Williams 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anemia 2 DAYS Due to (or as a consequence of): 2 DAYS BASTEONTESTINA Sequentially list conditions, if any leading to make the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 18 DAYS AS PIRATION PREMMON Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy nths? Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? ant conditions contributing to death but not resulting in the underlying cause given in Part I. DIARISA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed CANCER 2 **N**0 2 No 1 ∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2▼No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shore Examiner must be notified at

Directo

Funeral

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

is marked other

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is

Charlie

21215-0036

Baltimore, Maryland

aftending physician and for use as the burial-tran in 24 hours after with Funeral Director: After Funeral Director: After Funeral Funeral filled in by the funeral funera

Physician/Medical

≥

Be Completed

Certification: To

Medical

State

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

9 🗆 Unknown	
in the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	IF FEMALE:
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23b. Was decedent pre
9 🗆 Unknown	
	1 ☐ Yes 2 ☐ N
	9 🗌 Unknown
	Part II Other significa

> ' '		. •	-
none c	1000		
6113	ION		
	_	PENSION	

PROSTATE

6 Could not be determined

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

27. Manper of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

MO

RES- 000

APRIL 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

MANTNAN,

32. Registrar's Signature

HOSPITAL OF SIMM

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 7&8 Per FH G890 4/22/09 JH State of Maryland / Department of Health and Mental Hygiene amend #7&8 Per For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** CTOR T. TERRY APRIL 2009 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Examiner PRINCE MD 20735 GEORGES SOUTHERN MARTUAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1957 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 578-76-0327 1 XM 2 ☐ F 51 53 09/28/1955 D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Washington D.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20018 USA 2638 10th. Street NE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2X Married Saltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify. Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Document Specialist Printing - Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Percy Terry Sr. Ruby Devore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health ar 7216 Flower Avenue, Apt. 11, Takoma Park, MD20912 Terry / Daughter Bianca injury or other permit. Pages 1 and Department of Healt Important: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/21/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services iny ir Mow Short PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEPATIC ENCEPHALOPATHY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed AILURS NAL and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician UZURE Physician/Medical DISORDER the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year for 5 ☐ Other (specify) the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral . Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD. CLINTON MD 31. Date filed (Month, Day, Year) State APR 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1,10e&g Per Pyh &INF G890 4/24/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death David N. Trought Day Ye ar **Physician** Month 550 **₽** M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SURGICAL ICU BATMERE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 - 29 6. Sex Birthplace (State or Foreign Country) Funeral 1 M 2 □ F Months Days Hours Min. Year) 215-42-7005 Yrs. JAMICIA Director - 1933 Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked and process. mal 1 Yes 2 No Funeral Director Wood Bal 10e. Street and Number 10f. Zip Code 6801 10g. Citizen of What Country? Fox Meadow Road Jamaica 21207 . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Specify: Blaci 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vuneR d- Vern + Compano 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TRank ROUG Siranuels ပ becca 19a, Informant's Name/Relationship (Type (Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife helma Meadow tox 2120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Buria! 2 □ Cranation 3 Removal from State 17 09 4 Donation Other (Specify) new neral Servio MILLERS 21. Signature Lioensee 22. Name and Address of Facility Bicho 39 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spack, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTI ORGAN DAY FAILURE /Medical Due to (or as a consequence of): Examiner SEPTIC 1 DAY SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans FISTILA REGULANG The arpareurs WEEKS that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DISEASE REMAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RETECTED) 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ■ No 24a. Was an autopsy certificate Division of Vital 1 □ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier NPI 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) OSEPH SHUBER ລງ S. GREEN ST. 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Amend #11, perff g890 4/22/09 IT amend item 8 per fh g890 4-30-09 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>009</u> APRIL **Physician** 4:08 A M VENZE 18 **EDITH** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date Birth 5. Social Security Number **Funeral** Days Months 1 □ M 2 💢 F 88 MD 213-18-9541 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Nectoral Examiner must be notified at 1 ☐ Yes 2 1 No Funeral Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21209 2431 LIGHTFOOT DRIVE USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 X No WHITE Specify: Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry
CATONSVILLE COMMUNITY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COLLEGE MENTAL HEALTH INSTRUCTOR 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) **TATELBAUM** FRANCES HORNSTEIN HARRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau <u>once.</u> 10533 WILLIAM TELL LANE, COLUMBIA, MD ADRIENNE VENZE / DAUGHTER 20b. Place of Disposition (Name of OHEB SHALOM MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/21/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myouridal acute /Medical Due to (or as a conseque re of): Examiner Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be execufed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown 9 🗋 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown puleusca Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an dementer autopsy performed 1 ☐ Yes 2 ☑ No 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 2 ER/Outpatient 3 ☐ DOA 1 🗌 Inpatient Certification: To funeral 27. Manny of Death . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Iter 0 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , 2009 Year April 19, **Physician** 11:05am [™] Nolan Walton Alberta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Copper Ridge Sykesville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Nov 26, 1921 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 87 328-16-3182 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Walkersville MD Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 USA 62 Hampton Place by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 □ Yes 2 🙀 No Specify. Specify: White 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Etta (Unknown) John Nolan ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Hampton Place, Walkersville, MD 21793 Mr. George Walton (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial X ☐ Cremation 3 ☐ Removal from State All County Cremation 4/21/2009 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee PARTGET APONERALLY HOME & CHAPEL, P.A. MOOK4 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Atheroscleroni Cardisvascular Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FFMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 煤 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Road Westminister Mp 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19, Milye MAHMOUD TARIQ

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 12:20 PM pr: , 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner tosp:ce lowson Baltimore 7. Age_(In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🛛 F Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director atonsuille. 1 □Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō items 23a by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 2 No Blac 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 2121 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. Baltimore, Maryland Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be ouise 19b. Mailing Address (Street and Number Relationship ral Royte Number, permit. Pages 1 and 2 s
Department of Health at
Important; If item 27 is
any Injury or other trau Daughter MD21228 Catonsville 20a. Method of Disposition 20b. Place of Disposition cemetery, cremator 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, mi) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaughw C. Melle 5151 Batto. Nat'l Pile 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) detached Ö 9 Unknown 9 ☐ Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 2 No 1 □Yes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \textstyle Other (Specify) 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year)
AM1 21 2009 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 21, WILSON APRIL 2009 10:20 A.M CARL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5 KATHWAYS COURT CARNEY BALTIMORE Social Security Number 6. Sex 1 2 M 2 □ F 7. Age (In vrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 215-52-3982 59 11/21/1949 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 ANO Director MD BALTIMORE CARNEY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 KATHWAYS COURT 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give 1969-1971 Year or Dates! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ∐Yes 2 XX No Specify Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LOCKE INSULATORS. 12TH GRADE INSULATOR ASSEMBLER INC. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEROY WILSON PERITA JONES 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA WILSON/WIFE 5 KATHWAYS COURT BALTIMORE, MD 21234 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State METRO CREMATORY, INC. 4/22/2009 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EBANNIL PHLMONMY Y EVANLS disease or condition resulting in death) Due to (or as a consequence of): YEMS SANWIDOSI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Physician/Medical 3d. Date of delivery Month Day Year e contribute to the cause of death? 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No Be မှ ☐ Other (Specify) occurred

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760

Funeral

Director

'natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

h and Mental F

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau
once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Certification:

	resulting in death) Last	C. Due to (or as a consequence of):	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
•	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat
	TIME 2 DIMS	24a. Was an 24b. Were autopsy findings avai	
•	MINUNMY	HYMONTEN SIEN	autopsy prior to completion of cause death? 1 □ Yes 2 □ Yo 1 □ Yes 2 □ No
	25. Was case referred to medical	26. Place of Dea	ath (Check only one)
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	Home 5 Residence 6 ☐ Other (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D 15135

anil 21,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (BATMUNS, MD 21239 LOUS MON SLUD

State Registrar

Medical

within 24 hours a To the Funeral L

Jarke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 45 AM APPRIL Albert White Sr. 000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Woodbridge Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/04/1945 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 12 M 2□ F Months Days Min. 215-40-8584 63 S.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Y⊟Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 4809 Williston St. 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ XNo Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9 t h College (1-4or 5+) Machinist Adel Plastic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John White Georgia Mae Joe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn S. White/ Wife 4809 Williston St. Balto., MD, 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park04/29/09 | Randallstown, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 2 638 N. Gilmor St. Balto., MD, 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYUCANDIAL INFARCTION **Physician** CUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for us a consecuence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No 24a. Was an autopsy perform 1 □Yes 2 XNo Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILKENS AUE#307 SACT. IND 21225 12 BENEZER QUANDO un 31. Date filed (Month, Day, Year) Registrar's Signature 32 State

DHMH 17 Rev 1/2001

Registrar

back

Physician /Medical

Examiner

Funeral

Director

Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature apd title/of certifier

APR 2 2 2009

80. Name and address

31. Date filed (Month,

	Pleas							II Copies A	_) .
for State Registrar		State	of Maryl		oartment e <i>rtificate</i>			⁄lental Hygi ™	ene g. No. 2	9 12897
1. Decedent's Name	e (First, Middle,	Last)						Date of Death Month	Day Ye	3. Time of Death
D	onald	L. Wa	ard						20, 200	
4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, T	own, or Locati	on of Death		4c. County of D	eath
		al Cente				stmins	ter der 24 Hrs.			roll
5. Social Security N 219-44-7 Usual Residence of	963	6. Sex 1	7. Age (In 63	yrs. last birthda Yrs.		Days Hou	rs Min.	8. Date of Birth (Month, Day, May 29,	Year) 1945	Birthplace (State or Foreign Country) MD
10a. State	10b. County		10c	. City, Town or I	Location					10d. Inside City Limits
MD	C	arroll		Elder	sburg					1 □ Yes 2 X No
10e. Street and Nu		422011		Braci	10f. Zip	Code		10	g. Citizen of What	Country?
6525 Mel	lor Roa	d			2	1784		:	USA	
11. Marital Status		12. Was Dec		n U.S. 13	B. Was Decede	ent of Hispanic fy Cuban, Mex	Origin? (Sp	pecify Yes or No-		merican Indian,
1 Never Marr			2 X No		1 ☐ Yes 2			r nour, cto.,	Specify:	riile, etc.
3 Widowed		Year or D								White
(Spec	15. Decedent's cify only highest	Education grade completed)		ı (Gis	cedent's Usual	done durina i	most of work	ring 1	6b. Kind of Busine	ess/Industry
Elementary/Seco		College (1-4or 5+)		. DO NOT use employ	,	ck dri	ver	Truckii	no
17. Father's Name		ast)		Bell	Cmpicy			e (First, Middle, M		ng .
Joseph	F. Ward	, Sr.					Mary	H. Keen	ey	
19a. Informant's N	ame/Relationshi	ip (Type. Print)		19b. Ma	iling Address (Street and Nu	ımber or Rui	ral Route Number,	City or Town, Stat	e, Zip Code)
Patricia	A. War	d I	Wife_				T'	ersburg,		
		3 □ Removal from	State	b. Place of Dis cemetery, cr	ematory or oth	ner place)	4/23		Oc. Location - City Gamber,	,
21. Signature of Fu					22. Name and		· · · · · · · · · · · · · · · · · · ·	·		town Road
Lano	80	Cini		E	Eline F	uneral	Home		rstown,MI	
23a. Fart 1. Enter thock, or hea	he disease, or d ort failure. List o	omplications that	caused the deach line.	leath. Do not e	enter the mode	of dying, such	n as cardiac	or respiratory arre	st,	Approximate Interval Between
Ir prediate Cause disease or condition		. (plan	Cano	24					2/2000 - 4/27/00
resulting in death)	1	Due to	(or as a cor	sequence of):	00 T					
Sequentially list co	nditions,	b						_		
if any, leading to im cause. Enter Unde Cause (Lisease or	mediaté erlying	Due to	(or as a cor	sequence of):						
that initiated events resulting in death)	6	c	(or as a con	sequence of):						
		l Bue to	(0) as a con	sequence on.						
		d								
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[9 ☐ Unknown	months? ⊒No		birth 2 🗀 gnant at time	Fetal death 3	3 ☐ Ectopic pro				23d. Date of Month	delivery Day Year
Part II. Other signif	ficant condition	ns contributing to c	leath but not	resulting in the	underlying ca	use given in Pa	art I.	23e. Did toba	acco use contribute	e to the cause of death?
								1 ☐ Yes	s 2 □ No 3 □	Probably 4 Unknown
								24a. Was an	24b. Were	autopsy findings available
								autopsy perform 1 □ Yes 2	ed? prior	to completion of cause of
25. Was case refer	red to medical	L				26. P	lace of Deat	h (Check only one		2 2 1110
examiner? 1 ☐ Yes 2 ☑	No	Hospital:	Inpatient	2 ☐ ER/Outpati	ient 3 🗆 DOA	Other:		ome 5 Resider		Specify)
27. Manner Deat 1 Latural 2 Accident	h 5 Pending investiga	28a. Date (Mor		28b. Time Injury		c. Injury at Work? 1 🗆 Yes 2		28d. Describe how		
3 Suicide 4 Homicide	6 Could no determin	at ho	e of Injury - / ling, etc. (Sp	At home, farm, s pecify)	street, factory,	office		28f. Location (Str. City or Town,	eet and Number or State)	r Rural Route Number,
29a. Certifier (Check only one)	1 ○ Certifying 2 □ Medical E	xaminer: On the i	e best of my basis of exam	knowledge, de mination and/or	ath occurred a investigation,	it the time, dat in my opinion,	e and place, death occur	, and due to the ca red at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)

State Registrar mo

Letto Cotto Stroct
12. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

32.

29c. License number

29d. Date signed (Month, Day, Year)

MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day-Month **Physician** WALTER APRIL 9:30 AARON 20,2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE LEVINDALE 7. Age (In yrs. last birthday) Date of Birth (Month, Day, DEC 3 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 092-14-6136 6. Sex ^{Year)} 1920 NEW YORK 1 X M 2 □ F Months Days Hours Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE 1 Yes 2 □ No N/A MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 6606 PARK HEIGHTS AVE #109 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 🗓 No Specify: Specify: Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN INSURANCE 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROTENBERG **JACOB** WALTER HEDWIG ABRAHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1150 KERSEY RD, SILVER SPRING, MARYLAND 20902 DONALD WALTER/SON 20b. Place of Disposition (Name of BETH TSRAEL) Date 20c. Location - City or Town, State 20a. Method of Disposition 04/21/2009 1 XBurial 2 Cremation 3 Amemoval from State 4 Donation 5 Other (Specify) WOODBRIDGE, NJ 22. Name and Address of Facility 21. Signature of Juneral Service Licensee SOL LEVINSON & BROS., INC. Skall 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION Completed FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No RESPIRATORY 24a. Was an autopsy performed? /es 22 No 1∏ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes 1 4mpatient 2 ER/Outpatient 3 DOA ဥ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification:

Physician /Medical Examiner or Vital Records, P.O. Box 68760,

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the May Injury or other traumatic event, the Man

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ng physician and as the burial-transit attending physician certificate be use For ned by the a signed I been ate has bage 2 s Physician:

al or Attending Physician: 's after death.

I Director: After this certificate in by the funeral director, p n 24 hours at Hospital completely filled within 24 the

Division

Registrar

Medical

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 DNatural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

DUIZON H. WUNDEHINOT

D0063327

APRIL 21, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIZAW WOLDEHINGT, MD 2434 WIBELVEDERE AVE, BALTIMORE M.D 21215



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistranZMEND#10c,10e,10fperFH4/14/09,BW,MSertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month April **Physician** 03^y, 2ď🕏 10:15P M Irene V Berkovich /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casey House Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, January 9. Birthplace (State or Foreign **Funeral** Year), 1965 1 □ M 2 🖵 F Months Days Hours 44 Yrs. Russia 215-23-7626 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Eventinar must be notified and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bethesda Funeral Director 1 Yes 2 □ No MD Montgomery Rockvil 10e Street and Munberkerman Lane 10f 27 6 Code 7 10g. Citizen of What Country? United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify. If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Science Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vladimir Berkovich 2 Lidiya Barkhash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lidiya B Kovarskaya, Mother 10250 West Lake Drive #501, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4/10/09 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in de h) **Physician** Multiple Sclerosis /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

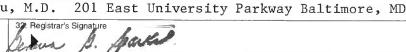
Jo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Hypertension attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☑ Unknown Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ∐Yes 1 ☐Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_4\Box$ Nursing Home $_5\Box$ Residence $_6$ \bigcirc Other (Specify) \bigcirc HOSpice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouatchou, m) Jocetyne 20063748 4/7/2009

State Registrar 31. Date filed (Month, Day, Year)

APR 0.8 200

Jocelyne T. Kouatchu, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



21218

			For		State of Ma	arylan		rtment o			/lental H	Hygiene	200	9	12900
			Registrar	ne (First, Mi <u>dd</u> le, Last)			Cer	uncate	Deau		2. Date of	Reg. No	o. — — —		2 Time of Dooth
	Physici	ian			and D),,,,,,,,	il Post				Month	Da	_		3. Time of Death
	/Medi			GF TREW		N/KF	HARDT	4b City Tow	n, or Location	n of Doath	04	0	3 25	29	02 40 M
	Examir	ner	0	1/1	- MEDICAI	(2	WIER	7R	A			1 40	. County of L	·	
	Funeral		5. Social Security N	Number 6. Sex			ast birthday)	If Under 1 Ye		er 24 Hrs.	8. Date of	Birth	9.	Birthpla	ice (State or Foreign
	Director		218-40-62	258	M 2□F	63	Yrs.	Months Da	ays Hours		JUNE 1	Day, Year,		Countr	LAND
	ъ		Usual Residence o								V 0.11.2 2	, 15			
	ırylar show	_	10a. State	10b. County			, Town or Loc	ation						100	d. Inside City Limits
	e Ma 8a-f s etifie	Director	MD	TALBOT		NE	WCOMB	,				_			XX Yes 2 □ No
	or 2	D.	10e. Street and Nu	mber				10f. Zip Cod				10g. Ci	tizen of What	Countr	y?
	ath v s 23a rust	Funeral	7370 STA						653				USA		
	er de item Der D	nu.	11. Marital Status		2. Was Decedent Armed Forces?		5. 13. V	las Decedent Yes, specify (of Hispanic C Cuban, Mexic	Origin? (Sp an, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - A Black, W		
36	s aft	by F	1 ☐ Never Marr	ied 2000 Married	1 XX es 2 ☐ I If Yes, Give Year or Dates:	NO	1	□Yes 2	No Specif	fy:			Specify:	лгт	'R
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vither than "natural"; or items 23a or 28a-f show ent, the Medical Evaminer must be notified at		o El Widowed	15. Decedent's Educ			16a. Deced	ent's Usual Oc	cupation			16b. K	(ind of Busine		
15	in 72 in "na inedii	plet	(Spec	cify only highest grade	completed)		(Give I	aind of work do	one during mo	ost of work	ing	100111		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	o <i>y</i>
212	with giene r tha	Completed	12	ondary (0-12)	College (1-4or 5)+)	MASTE	R PLUME	BER			RES	IDENT	[AL	PLUMBING
	al Hyg othe	Be C	17. Father's Name	(First, Middle, Last)		'			18. Moti	her's Nam	e (First, Mid	dle, Maider	Surname)		
/lar	Mental Mental rked c	To E	GEORGE FI	REDERICK BI	JRKHARDT,	JR.			IREN	NE MU	ELLER				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wedfell Examiner must be notified at	l.	19a. Informant's N	ame/Relationship (Typ	e. Print)		19b. Mailing	g Address (Str	reet and Num	ber or Rui	al Route Nu	mber, City	or Town, Stat	te, <i>Zip C</i>	Code)
	1 and 2 Health a em 27 is		J. FAYE	BURKHARDT-1	JIFE .		7370	MOITATE	RD.	NEWC	OMB, N	\mathbf{D} 216	553		
Baltimore,	of H of H if iten		20a. Method of Dis		moval from State	20b. PI	ace of Dispos metery, crem	ition <i>(Nam</i> e o atory or other	f place)	1	Date	20c. L	ocation - City	or Tow	n, State
Ĕ	Pages ment of I ant: If ite ury or o		4☐Donation	remation 3 □ Re 5 □ Other (Specify)	illoval Ilolli State	CHE	SAPEAK	E CREMA	TION	4/4/	2009	STEV	ENSVII	LE,	MD
alt	permit. Pages Department of Important: If is any injury or once.		21. Signature of Fu	uneral Service License	е		22.	Name and Ad	dress of Faci	ility	N S M	ATM AM	LTIMED A	LT D	OME, P.A.
ш	205 20		HOL	NR ME	RCERC		20	00 S. E	IARRISC	ON ST	EAST	ON, N	D 2160)1	orig, 1.a.
			23a. Part 1. Enter t shock, or hea	the disease, or complicant failure. List only one	ations that caused cause on each lir	the death ne.	. Do not ente	r the mode of	dying, such a	as cardiac	or respirator	y arrest,		1	Approximate nterval Between
Andre .	Physician		Immediate Cause disease or condition		COR	Pur	MOWAL	E						,	Onset and Death
	/Medical Examiner		resulting in death)	("	Due to (or as										
	Lxaiiiiiei	_	Sequentially list co	nditions, b.		BID	OBESI	74							
	ted isit	niner	if any, leading to im cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or as	a consequ	ence of):	1							
•	xecu and	Examin	that initiated events resulting in death)	C.	Due to (or as	a consequ	PNEA ence of):								
8760,	cate be executed physician and the burial-transit	alE			,	·									
687		edical		d.											
Вох	eath certifik attending p for use as	Physician/Me	IF FEMALE: 23b. Was deceden	t pregnant 23	c. If yes, outcome								23d. Date of	deliver	1
-	death e atte d for	icia	in the past 12 1 ☐ Yes 2 [months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregn Other (specify	ancy /)			_	Month		ay Year
P.0	at the de I by the stached	hys	9 ☐ Unknown		9 Unknown										
	The law requires that the death certif ate has been signed by the attending age 2 should be detached for use as	by P	Part II. Other signif	ficant conditions cont	ributing to death b	ut not resu	lting in the un	derlying cause	given in Part	t I.	23e. D	id tobacco	use contribut	e to the	cause of death?
Records,	v require been siç should b	ed t									1	yes 2	□No 3□] Probal	bly 4 🗌 Unknown
၁၁	aw re as be 2 sho	plet									24a. W		24b. Were	autops	sy findings available pletion of cause of
Ě	: The law cate has I page 2 s	Completed									pe 1 □Ye	utopsy erformed? s 2 D No	l death	ነ?	No
ita	ysician: The iis certificate director, pag	Be	25. Was case refer examiner?	red to medical				· ·	26. Plac	ce of Deat	h (Check on		, , , ,	103 2	azi i o
of Vital		10	1 ☐ Yes 2 🙀	Kio Ho	ospital: 1 Inpatie	ent 2 🗆 E	ER/Outpatient	3 □ DOA	Other: 4 🗆 N	Nursing Ho	me 5 R	esidence	6 □Other (5	Specify)	
n	ng P offer t inera	ü	27. Manner of Deat	h 5 ☐ Pending	28a. Date of Inju (Month, Day	ry y, Ye <i>ar)</i>	28b. Time of Injury	28c. I	njury at Vork?		28d. Descri	oe how inju	ry occurred		
<u>S</u>	tendi eath. or: A the fu	cati	2 Accident	investigation 6 ☐ Could not be				M	1 □Yes 2 □	No					
Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Injubul	ury - At hor c. <i>(Specify</i>	me, farm, stre	et, factory, offi	ce		28f. Locatio City or	n <i>(Str</i> eet ar Town, State	nd Number or e)	Rural I	Route Number,
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		00- 0 - ""												
	Hosp 24 hol Fune Fune	Medical	29a. Certifier (Check only one)	2☐ Medical Examin	er: On the basis o	f examinat	vledge, death ion and/or inv	occurred at th estigation, in r	ie time, date a ny opinion, de	and place, eath occur	and due to red at the tir	the cause(s ne, date an	s) and manne d place, and	r as sta due to t	ted. he cause(s)
	the thin 2 the omple	Med	29b. Signature and	title of certifier	and manner sta	itea.		29c Lic	ense number	,		29d Da	ite signed (M	onth D	av Vear)
				-			MD		8482						
	TLS		20 Name and odd	ress of person who con	aniated square of 4	ooth /itam	-		0,05				04 - 03	- 20	09
	2+VA		SHIVEW	0	5 10	N	CREEN	E 9	FACIN	NIDE	MO	2004			
	Sta	te	31. Date filed (Mon		32, Registra	ar's Signati	bar.	-1	710(00			2,20			
	Registr	-	A	PR 0 7 2009	1 /2 line	A	has	Kar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ye ar **Physician** Marc WILLIAM MARTIN BLIZZARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Viemorial Hospital Easton albot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 XX 2 F 216-38-9811 67 AUG. 5, 1941 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo TALBOT MD CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31817 GEIB RD. 21625 TIS Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Yes 🗶 No Specify. WHITE þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PLUMMER/PIPEFITTER UNION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ HOWARD BLIZZARD DOROTHY BRIDGE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA R. BLIZZARD-WIFE 31817 GEIB RD. CORDOVA, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FAIRVIEW CEMETERY 4-8-2009 CORDOVA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS HARRISON ST. HOME, P.A. buntelle 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIOBLASTOMA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I∐Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

the death certificate be executed burial-transi and P.O. Box 68760 Division of Vital Records, has To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I

as the use Be

4 Homicide

29a. Certifier

Medical

signed by the atte funeral filled in by the

Funeral

Director

death with the Marylan

permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f stany injury or other traumatic event, Its Medical Examiner must be notified any injury or other traumatic event, Its Medical Examiner must be notified once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

SILIAN

Dar - 20

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title pf certifier ohn Botsy M.D.

D0059487

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington St. Easten, MD 21601

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Da

09-02716 Sa

andy Janet Bo	nilla	State	of Maryland						gible.		
		1- For State Registrar		Certi	ficate of De	ath		Re	eg. No.	200	19 1291
Physici Medical Exami		Decedent's Name (First, Middle, Las Sandy Janet Boni	,					2. Date of Dear	Day	Year	3. Time of Death 0333 hrs
<u> </u>		4a. Facility Name (if not institution, giv			4b. Cit	y, Town, or I	Location of Dea	April 6, 20		nty of Death	
		Prince Georges Medical C	enter		Che	everly			Princ	e George	e's
Funeral		5. Social Security Number 6. Se	1	e (In yrs. last		nder 1 Year		din.			thplace (State or Foreign untry)
Director			M 2XF	19	Yrs.	IIIIIS Days	Hours	07/08	/1989		rginia
any		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	own or Location						10d. Inside City Limits
*	L	VA Fairfax			andria						1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number		112		Zip Code		1	0g. Citizen o	What Cour	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	ä	6632 Dorset Driv	e			22310			U.S.A		
n with ms 23 be no	eral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dece	edent of His		Specify Yes or No rto Rican, etc.)	- 14. R		can Indian, Black,
r death or ite	Funeral	1 X Never Married 2 Married	1 Yes 2	X No						T.Th.	ite
hours afte 'natural'',	à	Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	onloted) 1	1 Yes 6a. Decedent's Usu			Salvado:		ify: W11. f Business/I	
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5-0036 led within 72 Hygiene. other than	Completed		1		Student				N/A		
5-0 lled w Hygie other		17. Father's Name (First, Middle, Last)				1		me (First, Middle, I		ame)	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Itealth and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Be	Mario A. Bonilla 19a. Informant's Name/Relationship (T			40) 44-22- 4 11-			E. Cord		- 0.	
MD 2 nd 2 shoul aith and M m 27 is m	유	Mario A. Bonilla			19b. Mailing Addre			chester,			, ZIP Code)
and 2 and 2 lealth item 2		20a. Method of Disposition			ce of Disposition (I	Name of cen		Date			Town, State
nor other	.	1 X Burial 2 Cremation 3		ete Cre	matory or other pla Comfort	ce) Cemet	erv 04	/10/2009	Alexa	ndria	. VA
Baltimore, permit. Pages lar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licen			22. Name a	nd Address	of Facility		5755	Cast 1	ewellan Dr
E P P W		Kobert E	Enson	WI	Jeffe	rson	Funeral	l Chapel	Alexa	andria	a, VA
Physician /Medical		23a. Print I. Enter the disease, or comp silure. List only one cause on ea	lications that caused ch line.	the eath. D	o not enter the mod	de of dying,	such as cardia	c or respiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and
vaminer		the many that the same	Multiple Injuries								Death
		b	Due to (or as a conse	equence of):							
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
e executed cian and rial - transit		d.		•							
oe exel	dical	UNPENDED	AMENDED								
68760 certificate b rding physise as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregna	1-90					e of deliver	
Box 68760 e death certificate b the attending physical for use as the but	Physician/Me	past 12 months?		time of death	2 Fetal dea		Ectopic preg	gnancy	Mont	in L	Day Year
Box e death c the atten ed for us	hysi	1 Yes 2 No 9 V Unknown	9 Olikilowii								
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Fineral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transi	by P	Part II. Other significant conditions	contributing to death	n but not resu	ulting in the underly	ing cause g	iven in Part I.		-	ontribute to	the cause of death?
rds, Frequires	Ed							- 1 Yes			topsy findings available
cords, law requirence has been a 2 should	Completed					***		autop			completion of cause of
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of Vital Records, ng Physician: The law require there this certificate has been si meral director, page 2 should b	B	25. Was case referred to medical examiner?	lospital:	nt 2 🗸 El	R/Outpatient 3		of Death (Che	rsing Home 5	Residence	6 Other	-
n of V ing Phy After th	۲.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	Irv 2	8b. Time of Injury		y at Work?	28d. Describe			
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Division tal or Attendia is after death al Director: A	ifica	2 Accident Investigation 3 Suicide 6 Could not	28e Place of In	jury - At hom	e, farm, street, fact	ory, office b	uilding, etc.	28f. Location (3 or Town, S		ımber or Ru	ral Route Number, City
Divi	Certification:	4 Homicide determined	(Specify) Inte	erstate/Ex	press			S/B Interloop	195 @ Rt.1	College F	Park, MD
Division To the Hospital or Attend within 24 hours after death To the Fineral Director:		29a. Certifier (Check only one) Certifying Physici Medical Examiner	an: To the best of m								
To the J within 2 To the J complet	Medical	29b. Signature and title of certifier	and manner stated.	The state of the s		29c. License					nth, Day, Year)
		1110 1	1/1	24)		O.C.N			April 7,		, 22,, 100,
9 2	-	30. Nam- and address of person who	completed cause of d	eath (Item 23	3a)						
5)	-		ssistant Medical	,	,	Street, B	altimore, M	D 21201			
St	ate	31 Date filed (Month) Day, Year)	32. Registra	r's Signature	0 C			****			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Blackwell 2:32P James Ε. 31, 2009 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Capitol Heights Prince Georges 6400 Wilburn Drive 8. Date of Birth (Month, Day, Year) Oct. 14,1930 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**∑** M 2□ F Wash.,DC Director 579-36-0769 78 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Expanieer must be redified at Director 1 Maryes 2 □ No MD PG Capitol Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination once. 20743 United States 6400 Wilburn Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1955 Year or Dates: 1957 1 ☐Yes 2X No Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James S. Blackwell Irene 2 Warren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 Wilburn Drive
Capitol Heights, MD 20743

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

2 Mildred Blackwell/wife 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 4/6/09 Landover, MD 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. Suitland, MD, 20746 3910 Silver Hill Rd., 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm rate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? res 2 No 1 □ Yes 2 □No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🙀 Natural death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760, P.0. Division of Vital Records, To the Hospital or Attending after

within 24 hours a 54

> State Registrar

Medical

29b. Signature and title of certifier

4 Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Mercantile Lane Landover, md 2018 5

and manner stated

			1 = For State Registrar	State of	Marylar		artment <i>rtificate</i>		ealth and Death	Mer		ene O	09	12905
			Decedent's Name (First, Middle, La	st)						2.	Date of Death			3. Time of Death
	Physici		Dorothy 1	. Burnw	orth					A	Month pril	Day 14	2009	8:50 PM
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location of Dea		<u>r</u> – – —	4c. County		0.30 1
			Goodwill Mennor	ite Home	9		Gra	ants	ville			Garre	ett	
	Funeral	Г			7. Age (In yrs.	last birthday)	If Under 1	1 Year	If Under 24 Hrs		Date of Birth		9. Birthp	lace (State or Foreign
ь	Director		301-18-2678	1□M 2\\ F	87	7 Yrs.	Months	Days	Hours Min	N	(Month, Day, OV • 22.	1921	Cour	
	pu .		Usual Residence of Decedent 10a. State 10b. County		100 0	to Town and							1.	
	aryla eho	=				ty, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne M	Director	PA Fayett	.e		Conflue								
	with 1		10e. Street and Number	7			10f. Zip (10	g. Citizen of		ntry?
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	ter d	Funerai	11. Marital Status 1 Never Married 2 Married	Armed For	ces?	1.5.	vvas Decede If Yes, specif	fy Cuba	spanic Origin? (n, Mexican, Pue	rto Ric	an, etc.)		ce - Americ ck, White,	
36	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	9		1 ☐ Yes 2	⊠ No	Specify:			Specif	v: Whi	.te
5-0036	filed within 72 hours after deeth with the Maryland Hygiene. Stater then "neturel", or teme 23a or 28e-1 ehow ent, the Madical Examinar roust be notillised at	ted	15. Decedent's E	ducation			dent's Usual				1	6b. Kind of B	usiness/Inc	dustry
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2	d wit	ĕ	12	Conage (1		Н	ousewi	fe				Own H	ome	
Maryland	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other then "neturel", or Iteme 23a or 28a-f show aumatic event, the Madical Examinational to notified at	Be	17. Father's Name (First, Middle, Last)				ĺ	18. Mother's Na	me (F	irst, Middle, M	aiden Suman	ne)	
<u>a</u>	should band Ment and Ment amarked umatic e	2	Edwin McClint	cock					Bertha	Ja	ne Sal	keld		
a	and and send		19a. Informant's Name/Relationship (•		19b. Maili	ng Address (Street a	and Number or R	ural R	oute Number,	City or Town,	State, Zip	Code)
_	s 1 and 2 should f Health and Mer Item 27 Ie marke other traumatic		Donald Burnwo	orth					Rd., Con	- 4		PA 154	24	
altimore,	Jes 1 and 1 of Heal		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from S		Place of Dispo cemetery, crei	sition (Name natory or oth	e of ner place	9)	Date	2	0c. Location -	City or To	wn, State
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Ba	permit. Pages Depertment of I Important: If Ite eny injury or or once.		21. Signature of Funeral Service Lice				. Name and					Box 37		
	40 F 9 0		William R.	Price	CC03	/6 H	umbert	Fu	neral Ho	ome.	Confl	uence,	PA .	L5424
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that ca	used the deat ich line.	th. Do not ent	er the mode	of dying	, such as cardia	c or re	spiratory arres	st, ·		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a (1	spira	tion	Pn	1el	emonie	a				Onset and Death
	/Medical Examiner		resulting in death)	Due 10 (0	or as a conseq	juence of):	11	- /	itus					
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	and and II-trar	хап	that initiated events resulting in death) Last	c. Due to (c	r as a conseq	uence of):	1000							3418
9/90	icate be executed physicien and s the burial-transit	aE		7	7-1-1-1-1-1									,
28	the death certificate be executed y the attending physicien and iched for use as the buriat-transit	dical		d									:	
×	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregna	ancy						22d Da	te of delive	
ž	atter d for u	ciar	in the past 12 months?	1 Live bi	nth 2 ☐ Feta ant at time of d	l death 3	Ectopic pred							Day Year
oj.	that the de led by the a detached	ysi	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unkno			, a.i.a. (apar							
J	The law requires that ste has been signed bage 2 should be deta	by Pi	Part II. Other significent conditions	ontributing to de	ath but not res	ulting in the u	nderlying cau	use give	n in Part I.		23e. Did toba	cco use cont	ribute to th	e cause of death?
cords,	w requires that s been signed t should be det	D D									1 🗌 Yes	2 X No	3 Prob	ably 4 □Unknown
င္ပ	w rec	lete									24a. Was an	24h 1	Ware autor	osy findings available
Ĕ	iclen: The lar certificete hes rector, page 2	Completed					-			ŀ	autopsy		prior to con death?	noletion of cause of
NIT A		ပိ	25. Was case referred to medical						00 51 (5				I ☐ Yes	2 X No
	Physiclen: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 1 No	Hospital:	patient 2	ER/Outpatien	t 3 DOA	Othe	26. Place of De					
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<u> </u>	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation		, Day Year)	Injury	м		? 'es 2 ☐ No					
DIVISION	Atte octo by th	IIIC	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place (of Injury - At he	ome, farm, str	eet, factory,	office		28f.	Location (Stre	et and Numb	er or Rura	Route Number,
5	s after	Certification;	1 10111000	Dullan	g, etc. (<i>Specif</i>	γ)					City or Town,	State)		
	To the Hospital or Attending Physicien: which 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the t	pest of my kno	wledge, death	occurred at	the tim	e, date and place	e, and	due to the cau	se(s) and ma	inner as st	ated.
	in 24 in 24 ihe F	edicai	(Check only 2 Medical Examone)	and mann	er stated.	tion and/or inv	estigation, ii	n my op	inion, death occi	urred a	t the time, dat	e and place, a	and due to	the cause(s)
	To To I	Σ	29b. Signature and title of certifier	11	1				number		290	d. Date signed	d (Month, L	Day, Year)
			Solbahe	& NO	huab		10	50	8655	>		4/15	120	08
			30. Name and address of person who	completed cause	of death (Item	23a) (Type,						1		
			Sabahat Nawab, I				alsh D	r.,	Cumberl	and	, MD 2	1502		
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 2 200		gistrar's Sign	ture Jack	de de							

09-02841 Benjamin Burger, Jr		Ple For State	ase Typ St	e or P ate of N	rint in B Maryland	/ Depart	mer	le Ink. Er nt of Healtl e of Death	h and	All Copie Mental Hy	s Ar ⁄gien	e Legib ie Reg. N	2	00	9 1290
Physician/	1.	gistrar Decedent's Name Benjam			urger,						Mon Apri	of Death th Day 19, 2009	y Year		Time of Death 1630 hrs
	48	a. Facility Name (it	not institutio	n, give stre	et and number	r)		4b. City, To		ocation of Death Hagers	town	n	4c. County of Di Washington	n	
Funeral Director	1	Social Security N		6. Sex		ge (In yrs. last 22		ay) If Under Months	er 1 Year s Days	If Under 24Hrs Hours Min.	٦ .	ite of Birth (M		Countr	ace (State or Foreign y) ryland
, any	U	sual Residence of				10c. City, To	own or								d. Inside City Limits Yes 2 XXNo
the Maryland a or 28a-f shoviffied at once.	M 1	aryland Oe. Street and Nu	mber	shingt				Clear 10f. Zip	Code	722		10g.	Citizen of What Country? USA		
er death with 1 , or items 235 r must be not	1	13544 E 1. Marital Status 1. X Never Marri 3. Widowed	ed 2 N	12.	. Was Decede	nt Ever in U.S. s? 2 X No		If Yes, specif	ent of His fy Cuban	panic Origin? (Si, Mexican, Puerto	pecify Y Rican,	etc.)	14. Race - A White, e		Indian, Black,
5-0036 ed within 72 hours after bygiene. other than "natural". the Medical Examine. Completed by		15. Decedent's E	ducation (Sp	ecify only h	Jares:		16a. D di	ecedent's Usual uring most of wo	Occupat rking life	ion (Give kind of DO NOT use ret	work do	one 16	b. Kind of Busin		
de within 72 siene. Spiene. Somple		12 7. Father's Name	(First, Middle	e, Last)			_	Lab	orer	18.Mother's Nam				ruct	10n
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than it event, the Medical To Re Comple		Benjami 19a. Informant's N	ame/Relation	ship (Type			19b	. Mailing Address	s (Stree	Susan et and Number or Valley	Rural F	Route Numbe	Siler Spring	State, Z	ip Code) 21722
re, MD shall and 2 shall and 1 shall and 1 fitem 27 is er traumat	-	Benjamir 20a. Method of Dis 1 X Burial 2	sposition			20b. P	lace of	f Disposition (Na	me of ce	metery,	Date	e 2	20c. Location - C	ity or To	wn, State
Baltimore, MD permit. Pages I and 2 sho perminent of Health and Inportant: If item 27 is injury or other traumati			5 Other	Specify:		Res	st I	22. 9 and 1910	1⊕ddet	ery Apr mered H nocochea	ome.	, P.A.			n,Maryland MD 21795
Physician	-1	23a. Part I. Enter failure. List o	nly one caus	se on each	tions that caus line. est Injuries		Do no	t enter the mode	of dying	, such as cardiac	or resp	iratory arrest	t, shock, or hear	t	Approximate Interval Between Onset and Death
.aminer		Immediate Cause or condition result	ting in death)	Due b.	e to (or as a co	onsequence of									
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medic	IF FEMALE: 23b. Was deceded past 12 mont		n the	1 Live birt	nt at time of de		Fetal deat Other (Sp.		Ectopic preg	gnancy		23d. Date of o	Da	
P.O. B es that the de grand by the be detached.	اھ	Part II. Other sig	Inificant con	ditions co	ontributing to c	leath but not re	esultin	g in the underlyi	ng cause	e given in Part I.					ne cause of death? ably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require as the death an Director: After this certificate has been sixed in by the funeral director, page 2 should be in by the funeral director, page 2 should	Completed										-	24a. Was a autops perforr 1 Yes 2	y p med? d	vere auto nor to co leath? Yes	opsy findings available ompletion of cause of
ital Esician: Sician: Sician:	å	25. Was case re examiner?			spital: 1 In	patient 2 🗸	ER/C	Outpatient 3	DOA	Other Nu	_		Residence 6	Other:	
on of V nding Phys th r: After thi	tion: To	1 V Yes 27. Manner of De 1 Natural	5 P	ending	28a. Date o (Month Apr 9, 20	f Injury Day,Year) 09		Time of Injury 00 hrs	_	njury at Work? Yes 2 No	im	palement		n roof	while at work
Divisical or Atte urs after degrand Directo	Certification:	2 Accident 3 Suicide 4 Homicid	6 🗌 c	nvestigation could not be etermined	28e. Place (Specify)	Workplace	е	farm, street, fact			173	311 W. Was	shington St., E	icar U	
o the Hosp ithin 24 hor o the Fune ompletely fi	Medical C	20a Cortifica		Examiner:	n: To the best On the basis of and manner sta	f examination a	dge, de and/or	investigation, in	my opin	, date and place, ion, death occurr	and due	e to the cause e time, date a	e(s) and manner and place, and d	uc to the	
→ = = = = = =	Me	29b. Signature a	and title of ce	rtifier	4h11.	mo				C.M.E.			April 10, 20		iiri, Day, rear)
SH-6		30. Name and a	ddress of per E. Southal		Assistant N	Medical Ex	amin	er 111 Pe	enn Str	eet, Baltimore	e, MD	21201			
St Regist	ate rai		APR	13 20	09 32. R	gistrar's Signa	ture	fact	1					·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Elsie Alberta Bryan 10:20p.m 04 2009 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17102 Horsehead Road Brandywine, Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F **Director** 88 577**-**26**-**1913 07/16/1922 BADEN, MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo PRINCE GEORGES Directo MD. BRANDYWINE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 17102 HORSEHEAD ROAD 20613 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2☐No Specify. \$ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be JAMES CANTER FRANCES SMITH ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY BRYAN-PRELL DAUGHTER 10137 VALENTINO DR. OAKTON, VA. 22124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.PETER'S CEMETERY 4-20-09 WALDORF, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 3 months Cardio-respiratory failure due to multiple myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ф 9 Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes ŽŽNo 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate 2**X**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 20 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury .: 0 After 28d. Describe how injury occurred 1 ANatural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Certificat 24 hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Celucia D0014818 04/15/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 387 LaPlata, Maryland 20646 M.D.

State Registrar Guillermo E.

31. Date filed (Month, Day, Year)

Sanchez,

APR

32. Registrat's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Farl B. Cannon April 4, 2009 11:00aM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1**XX**M 2□ F Months Days Hours Min Director 406-40-1311 75 May 9, 1933 KY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exyminations to positive and 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3230 Hewitt Avenue, #5 20906 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1XYes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 MMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Communications Computer Billing Department 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry H. Cannon Sylvia B. Conklin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa C. Cannon / Wife 3230 Hewitt Avenue, #5, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State April 8, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 weller 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Hypovolemic Shock Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Rectal Bleed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE yes, outcome of pregnancy
Live birth 2 Detail death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2 No 5 Other (specify) detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate perform 1 □Yes 2XXNo 1 ☐Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 Yes 2 No 1 🔯 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural after death death 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) + D0012962 April 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Zorayda Lee-Llacer, M.D.

08

31. Date filed (Month, Day, Year)

APR

Laurel Regional Hospital

32. Registrar's Signature

7300 Van Dusen Rd., Laurel, MD 20707

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Erma Vivian Campbell April 11:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel South River Health & Rehab. Center Edgewater 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Teb. 23, 1 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F Months Days Hours Min. 98 Director 1911 Illinois 490 - 20 - 9470 Feb. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at Maryland Director 1 ☐ Yes 2 No Anne Arundel Edgewater 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3467 Monarch Drive 21037 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ∑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: þ Specify: White 3 ☐ Widowed 4 ☒ Divorced "natural", Completed or than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistician Dept. of the Army f Health and Mental Hygier Item 27 Is marked other th other traumatic event, In-12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles Price Marie Falter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important; If item 27 any injury or other tr once. JoAnn M. Greig / Daughter 3534 Egret Drive Melbourne, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) National Memorial Park 4-7-2009 Falls Church, Virginia 21. Signature of Funger Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Theimer's Physician disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the aftending physician and aftending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the detached 9 Unknown signed by 1 I be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 🖼 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April GTA 2009 MD Duu53709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gallent Fox lam STE# 210 Bowle KAT 14300 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar

APR 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 2,2009 Year **Physician** 14:18 M Jimmie Castret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrest Center 8. Date of Birth (Month, Day, Year) 8/11/1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☑ M 2 □ F 79 408-34-4217 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once. 1 ☐ Yes 2 🔀 No Director Crownsville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21032 USA 92 Summer Hill Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No II ¥es, Give 48-69 Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Army Master Sgt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Ricketts Castret Edna James Peter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1143 Wharf Drive Pasadena, Maryland 21122 Heidi K. Dorsey Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4/7/09 Davidsonville,MD Lakemont Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12 Ridgely Ave Hardesty Funeral Home P.A. Annapolis,MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CORONARU LEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DIABETES 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown funeral director, page 2 should PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No DEMENTIA 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D64395 APRIL 2, 2009 of person who completed cause of death (Item 23a) (Type, Print) DANIEUR DOBERMAN, MO 6565 NEMAPLES ST, SUITE 209 BALTIMORE, MO 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

09-02842	
Courtney Cristallon	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Registrar	Death	2000 1201 eg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)	Date of Deal Month	Day Year
vieuicai Examinei	oddrency bried oribodizo	April 9, 20 4b. City, Town, or Location of Death	4c. County of Death
	400 Howard Avenue	Arnold	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 32 Yrs	Months Days Hours Min. 11/12/	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion	10d. Inside City Limits
<u> </u>	Maryland Anne Arundel Arnold		1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 400 Howard Avenue	10f. Zip Code 1 21012	Og. Citizen of What Country? United States
r death wire or items	1 Never Married 2 Married Armed Forces? If Y 1 Yes 2 No If Yes, Give Year or Dates:	is Decedent of Hispanic Origin? (Specify Yes or No res, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:	14. Race - American Indian, Black, White, etc. Specify: White
ore, MD 21215-0036 s. I and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", her traumatic event, the Medical Examine To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ACCOUNT	nt's Usual Occupation (Give kind of work done lost of working life. DO NOT use retired) hting Clerk	16b. Kind of Business/Industry Accounting
21215-00% Uld be filed withi Mental Hygiene, marked other ti e event, the Med	Carmen F. Cristallo	18.Mother's Name (First, Middle, I Shawn Lunden	Maiden Surname)
e, MD 21 I and 2 should Health and Me item 27 is ma	Kristofer M. Cristallo/Brother 211 S	g Address (Street and Number or Rural Route Num Sycamore Road, Severna I	Park, Maryland 21146
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If liem 27 is marked other than injury or other traumatic event, the Medica To Be Comple	1 Burial 2 X Cremation 3 Removal from State Kalas Crematory or ot 4 Donation 5 Other Specify	natory 04/15/2009	20c. Location - City or Town, State Edgewater, Maryland
	29	Name and Address of Facility George P. 73 Solomons Island Road	, Edgewater, MD 21037
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a Narcotic (morphine)		est, shock, or heart Approximate Interval Between Onset and Death
xaminer	or condition resulting in death) Due to (or as a consequence of):		
miner	Sequentially list conditions,		
760, cate be executed cate be executed physician and the burial - transit //Medical Examiner	events resulting in death) Last Due to (or as a consequence of): d.	- MF ~900 / /27700 mm	
760, icate be executed g physician and the burial - transi	XUNPENDED X AMENDED $\#1$ as noted pe $23a,27,28a-f,1$	perME, g891 5/11/09 TT	
	23b. Was decedent pregnant in the	etal death 3 Ectopic pregnancy ther (Specify)	23d. Date of delivery Month Day Year
D. Box 68 t the death certi by the attending to the diverse as	1 Yes 2 No 9 V Unknown 9 Unknown		
ires that the d signed by the 1 be detached	`		obacco use contribute to the cause of death? s 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician		1 Yes	prior to completion of cause of death?
/ital sician sician sicienti sis certi sirector	25. Was case referred to medical examiner? 1 Moor 2 No. 2 No. 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check only one) t 3 DOA Other Wursing Home 5	Residence 6 ✔ Other: Scene
on of Vinding Physical The After this efunctal dir Ton: To	27 Manner of Death 29s Date of things 1 39h Time of	Injury 28c. Injury at Work? 28d. Describe unk	how injury occurred
Division o spital or Attending hours after death. neral Director: After filled in by the func Certification:	2 Accident Suicide Accident Suicide Accident Accident Suicide Accident Accident Suicide Suicide Accident Suicide Suici	et, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City State) 400 Howard Ave
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occuone) 2 ✓ Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, and due to the cau-	se(s) and manner as stated.
F » F »	29b. Signature and title of certifier	29c. License number O. C. M. E.	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.O.IVI.L.	April 10, 2009
	Donna M. Vincenti, MD Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 21201	
State Registra	31. Date filed (Month, Day, Year) APR 17 2009	Ne o	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Thomas David Cater, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 362-36-3574 73 Director Jan. 12,1936 SC Usual Residence of Decedent death with the Maryland r 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Xes 2 □ No Funeral Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 11320 Snow Owl Place #A 20603 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian filed within 72 hours after 1 Never Married 2 Married 15-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black Completed by 3 ₩ Widowed 4 □ Divorced "natural" event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, Ite Ma Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Private and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be f David Cater ဥ Lula Mae Hawkins Pages 1 and 2 should ary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #A Waldorf, MD 20603
Date 20c. Location - City or Town, State Wendy Cater-Pratt/Daughter 11320 Snow Owl Pl. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other plank iverdale Park Crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/13/09 Riverdale Park,MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee 2294 Old Washington Rd. Waldorf, MD. 20601 Spear. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Lucen /Medical Due to (of a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (of as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

To the Hospital within 24 hours a To the Funeral I Hospital

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State Registrar 29b. Signature

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and address of perso

31. Date filed (Month, Day, Year) APR 0 8 2009

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death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009 Year **Physician** 4, Lottie June Costantino April 9:40aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 87 Yrs. 578-14-2609 Middleburg, VA Director 6-3-21 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Eventual be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1√2Yes 2□No MD Prince Georges Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20782 United States 5502 Sargent Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian 11. Marital Status 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Crowder Celia Flynn John ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis L. Costantino/Son P.O. Box 688 Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 4-7-2009 Brentwood MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Rd, Brentwood MD 20722 ash 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) evosal 🧎 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Director: After that in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 04-04-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA thur. ~ 4 10 BLVD Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr 14, 2009 **Physician** Carder Donna Lee 11:00am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2 New Hampshire Avenue Cumberland Allegany 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 1, **Funeral** 1 □ M 2 □ ▼ Months Days Hours Min 218-62-6279 56 Director Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Missical Examines must be notified MD Allegany Cumberland Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 New Hampshire Avenue 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married 1 □Yes 2 □No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify 2 Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Head Nurse Hospital Rehab Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Randolph Robertson Glenda Jean (Piper) ၉ 19a. Informant's Name/Relationship (Type. Print) Richard Carder Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 New Hampshire Cumberland MD 21502 Pages 1 and 2 si ment of Health an ant: If Item 27 is I husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 4/20/200b LaVale MD 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ee 22. Name and Address of Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or conjucations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one calls you each line. Approximate Interval Between Onset and Death Immediate Cruse (Final disease or or ndition resulting in a ath) **Physician** /Medical sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 E No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2/2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation neral Director: A death. 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017565 -16,2009 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 21502 an LaVALE AJBOllini 31. Date filed (Month 32. Ref istrar's Signature State Registrar

DHMH 17 Rev 1/2001

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within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

E 25. Was case ref examiner? 1 TYes 2[27. Manner of De 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

one)	and manner stated.	
29b. Signature	and title of certifier	

29c. License number
D16711 29d. Date signed (Month, Day, Year)
April 15, 20 15, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Civingston Rd., Ft. Washington, 4D. 20744 Deepak Sachdeva MD, 11711 31. Date filed (Month, Day, Year) 32. Registrar's Signature

marke

State Registrar

DHMH 17 Rev 1/2001

Medical Certification: To

(Check only

APR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar	Certificate of Dea	ath	,	Reg. No. 200	9 29 6
ì	Physici	an	Decedent's Name (First, Middle, Last) Ada Romaine Davis			2. Date of Dea Month April 6	Day Yea	3. Time of Death 8:28p M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) Suburban Hospital	4b. City, Town, or Local		April 0	4c. County of Di	eath -
*	Funeral Director		5. Social Security Number 209–22–3428 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last bite of the property of the p		urs Min.	B. Date of Birt (Month, Da June 7,	th 9. E	Birthplace (State or Foreign Country) Maryland
	e Maryland Ba-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow MD Montgomery	Bethesda_				10d. Inside City Limits 1 □ Yes ②XXNo
	th with the 23a or 2	Funeral Director	10e. Street and Number 6400 Wilmett Road	10f. Zip Code 20817			10g. Citizen of What USA	Country?
980	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exertime must be rediffed at	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of Hispani If Yes, specify Cuban, Me 1 □ Yes 2\1\1 No Spe	ic Origin? (Spec exican, Puerto R ecify:	ify Yes or No- ican, etc.)	- 14. Race - A Black, W Specify:	merican Indian, hite, etc. White
21215-0036	vithin 72 ho sne. than "natur than"	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Associate Dean	most of working	9	16b. Kind of Busine	
land 2	be filed ntal Hygi nd other event, I	To Be Co	17. Father's Name (First, Middle, Last) Louis Berge Romaine	18. N	Mother's Name (Maiden Surname)	
Maryland	ad 2	-	19a. Informant's Name/Relationship (Type. Print) Kevin Murray Davis / Son	Mailing Address (Street and N 2308 Washington				
Baltimore,	0 O		1 Rurial 2XXCremation 3 Removal from State cemeter	Disposition (Name of y, crematory or other place) Litan Crematory	April 8		20c. Location - City Alexandria	
Balt	permit. Page Department Important: In any Injury o		21. Signature of Funeral Service Licensee	22. Name and Address of F Francis J. Col 500 University	lins Fune	eral Home est, Silv	e Inc. ver Spring,	MD 20901
	Physician /Medical Examiner		23a. Part 1. Enter the alsease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as e consequence	Arten D	ch as cardiac or		rrest,	Approximate Interval Between Onset and Death
68760, %	certificate be executed rding physician and ise as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence c.					
P.O. Box 687	that the death certificate be executed led by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∑XNo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
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al Reco	t: The law rec icate has bee r, page 2 shou	Completed by				1 □ Yes	prior death	e autopsy findings available to completion of cause of n? Yes 2 \(\subseteq \text{No} \)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	ion: To Be	1 DNatural 5 Pending (Month, Day, Year)	tpatient 3 DOA Other: 4 Time of njury 28c. Injury at Work?	28	e 5 ☐ Resi	nne) dence 6 □ Other (5 how injury occurred	Specify)
Divisio	al or Attending s after death. il Director: After ed in by the fune	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, for building, etc. (Specify)	M 1 □Yes		8f. Location (8 City or Tox		r Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge on the basis of examination a and manner stated.	, death occurred at the time, dad/or investigation, in my opinior	ate and place, a n, death occurre	nd due to the d at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
		Me	29b. Signature and title of certifier	29c. License num 7 6 6			29d. Date signed (M	1
	15		30. Name and address of person who completed cause of death (Item 23a) Matthew Leonard 8600 Old Georgetown	• • • • • • • • • • • • • • • • • • • •	20814			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	harris				

DAVIS, ADA 4/4/09 8:28PM

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		I- For State Registrar	Cen	tificate of I	Death		2. Date of De	Reg. No.	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) James Dorsey					Month April 2, 2	Day Yea	3. Time of Death 1614 hrs
		4a. Facility Name (if not institution, give str	eet and number)	4b	. City, Town, o	r Location of De		4c. County	of Death
-30d		Calvert Memorial Hospital			Prince Fre			Calvert	
Funeral Director			7. Age (In yrs. la	st birthday) 82 Yrs.	If Under 1 Ye Months Da		. 4: .	25 1926	7) 9. Birthplace (State or Foreign 例確如yland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	า				10d. Inside City Limits
*	٦	Maryland Anne Aru	ndel Lo	thian					1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	hat Country?
death with the Maryland or items 23a or 28æ-f sho must be notified at once		5501 Sands Rd.			207			USA	
eath with the items 23a	uneral	11. Marital Status 1 Never Married 2 X Married	. Was Decedent Ever in U.S Armed Forces?				(Specify Yes or Nerto Rican, etc.)		e - American Indian, Black, e, etc.
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Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N important; If item 27 is in injury or other traumatic		Edith R. Dorsey						, Md. 2	
5 2 2 5 a		20a. Method of Disposition 1 X Burial 2 Cremation 3		lace of Dispositi rematory or other			Date		- City or Town, State
time t. Pag tment rtant;		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	C	hurch		4	4-8-09		ian, Md.
Baltimo permit. Page Department of Important:	V	21. Signature of Funeral Service Licensee						tuary, is, Md.	
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Con Examiner		or condition resulting in death)	to (or as a consequence of):					
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Box 68760, e death certificate be execut the attending physician and ed for use as the burial - trai	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the	3c. If yes, outcome of pregr		Ideath 3	Ectopic pre	ananau	23d. Date of Month	
x 68 h certil	iciar	past 12 months?	Live birth Pregnant at time of dea	th	Ideath 3 er (Specify)	Ectopic pre	griancy	Month	Day Year
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be refear. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri	by P	Part II. Other significant conditions con	ntributing to death but not re	sulting in the un	derlying cause	given in Part I.		-	ibute to the cause of death? Probably 4 Unknown
dS, Fauries equires and be unid be									Were autopsy findings available
COTC law re has be	Completed						per	ormed?	orior to completion of cause of death?
Re It The tifficate		25. Was case referred to medical			26 Plac	ce of Death (Ch		2 V No 1	Yes 2 No
/ital ysician his cerr directo	o Be		oital: 1 Inpatient 2	ER/Outpatient		Other:	ursing Home 5	Residence 6	Other:
n of \ding Phy. After tl funeral	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj	ury 28c. Inj	ury at Work?	28d. Describe	how injury occurr	red
Sion Attendii death. sctor: /	atio	1 Natural 5 Pending 2 Accident Investigation			1	Yes 2 No	35		
Division ral or Attendii rs after death. al Director: A	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, street,	factory, office	building, etc.	28f. Location or Town,		er or Rural Route Number, City
Divi ospital or hours afte uneral Div	O	4 Homicide	(Specify) To the best of my knowledg	o dooth poores	ed at the time	data and alaca	and due to the co	uso(s) and manner	r en etatod
Divis To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	one) 2 • Medical Examiner:Or	the basis of examination ar						
6 000	Me	29b. Signature and title of certifier	d manner stated.		29c. Licer	se number		29d. Date sign	ed (Month, Day, Year)
and a)	high .	(Com		0.0	.M.E.		April 3, 200	09
349	22	30. Name and address of person who com Ling Li, MD Assistant Med		^{23a)} Penn Street	, Baltimore	, MD 21201		0	DOME
St Regist	ate trar	31. Date filed (Month, Day, Year) A PR 0 7 2009	32 Registrar's Signatu	bar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorden Month **Physician** 0715 A Marion WALLACE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charles

9. Birthplace (State or Foreign Country) 2358 Mail Coach Court Waldorf If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 04/22/1933 7. Age (In vrs. last birthday) **Funeral** 4-88-361 Months Davs Hours Min. Director Georgia Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10b. County the Medical Examiner must be notified at 1 □Yes 2 No Director Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2358 Mail Coach Court 20602 items 23a USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 Mayes 2 □ No
If Yes, Give
Year or Dates: 1951-1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 'natural", or Specify. ģ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Its Mo Elementary/Secondary (0-12) College (1-4or 5+) Construction Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Dorden <u>Annis Belflower</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dell Dorden/ Wife 2358 Mail Coach Ct. Waldorf, Maryland, 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Ridge Cemetery April 9, 2009 Tifton, Georgia 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service m01284 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diaseten **Physician** YEAS disease or condition resulting in death) /Medical Examiner Con gestive Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner requires that the death certificate be executed Examin physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No has e 2 s page certificate 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No ieral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 7 Section 1 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and ti le of D0055724 Charlotte Hall Road Charlotte Hall MD 20602 30. Name and address Jean Estime 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

APR 0 8 2009

09-02718 Ronald Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

aid Davis		For State	of Maryland / Depa Ce	rtificate of L		іаі пууі	Reg.	No.	2009	129
Physician	/ 1	egistrar . Decedent's Name (First, Middle,Last)				ate of Death	Day Year	3. Time of	
dical Examine		RONALD DAVIS		I 4h	. City, Town, or Location of	A	pril 6, 2009	4c. County o	0454	nrs
	4	 Facility Name (if not institution, given Prince Georges Hospital C 			Cheverly	Death		Prince G		
Funeral	5	. Social Security Number 6. Se		last birthday)			Date of Birth	(MM/DD/YYYY	9. Birthplace (Sta Foreign Wash	te or
Director		577-66-3160	M 2 F 6	O Yrs.	Months Days Hours	Min.	12/16/	1948	Country) DC	
any	_	0a. State 10b. County	10c. City	, Town or Location	1					e City Limits
Maryland 28a-f show d at once.	5 L	DC	Wa	shington					-	s 2 No
the Maryland a or 28a-f shu lifted at once	2 7	0e. Street and Number			10f. Zip Code			j. Citizen of Wh		
th the		720 49th Street N	E 12. Was Decedent Ever in U	13 Was	20019 Decedent of Hispanic Orig	nin? (Specify		nited S	tates - American Indian,	Black.
er death with the Maryland , or items 23a or 28a-f sho r must be notified at once.		1 X Never Married 2 Married	Armed Forces?	If Yes	s, specify Cuban, Mexican	, Puerto Rica	an, etc.)	White		,
s after d		3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		es 2 X No specify:		_	Specify:	Black	
hours a	ב ב	15. Decedent's Education (Specify or	nly highest grade completed)		s Usual Occupation (Give st of working life, DO NOT			16b. Kind of Bu	siness/Industry	
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan		Elementary/Secondary (0-12)	College (1-4 or 5+)	T 1				Desire		
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	<u></u>	7. Father's Name (First, Middle, Last)		Laborer	18.Mother	's Name (Fir	rst, Middle, Ma	Privat aiden Surname))	
215 be file ntal H rked of rked of		Marci Davis			Add	die Wa	lker_			
D 21 should nd Me is ma is ma	-	9a. Informant's Name/Relationship (T		17	Address (Street and Nun)
and 2 sho ealth and tem 27 is traumati		1izabeth Smith /	Sister 20b	4815_T Place of Disposit	exas Street on (Name of cemetery,	NE Wa	shingt ate	20c. Location	City or Town, State	te
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marnal Hygin and I mortants: I friend 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once TO Bo Completed by Eumoral Director	1	1 Burial 2 X Cremation 3		crematory or other	. ,	, , , , , ,	,,,,,,,	4 4	1 /	
Baltimore, permit. Pages I an Department of Hee Important: If itel injury or other tr	+	Donation 5 Other Specify 1. Signature of Funeral Service Lice	see Me	tropolit 22. Na	me and Address of Facility	14/25/ X1evan	2009 I	Pone 1	iria. VA Euneral E	lome
inji inji Dep 📆	ı	Kith a. su	nd M0118	7 1261	7 Penneylvai	nia Av	SE.	Washing	ton. DC	20020
Physician	1	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the deat	h. Do not enter the	e mode of dying, such as o	cardiac or res	spiratory arres	st, shock, or he	Betwee	mate Interv n Onset an
/Medical caminer			Atherosclerot: Due to (or as a consequence		ovascular di	sease			-	Death
	-1	b	Due to (or as a consequence	01):						
		cause Enter Ungertytha Cause	Due to (or as a consequence	of):						
ted Insit		Disease or injury that initiated C.	Due to (or as a consequence	of):						
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eath certificate be executed eath certificate be executed for use as the burial - transition in the purial - transition is a second of		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of pre	-	al death 3 Ectopi	ic pregnancy	/	23d. Date of Month	Day	Year
Box 687 death certific the attending p ed for use as th	icia icia	past 12 months? 1 Yes 2 No 9 Unknown	Pregnant at time of o	ieath 5 Oth	er (Specify)					
the dea	Physician	Part II. Other significant conditions	9 Olikilowii	resulting in the ur	derlying cause given in P	art I.	23e. Did tot	pacco use contr	ribute to the cause	of death?
res that the d signed by the be detached	a	art II. Other signmeant conditions	continuating to death but not	resulting in the en	don'y mg daedd gron my		1 Yes	2 No 3	Probably 4	/ Unknowr
law requires has been sign 2 should be	ered						24a. Was a		Were autopsy find prior to completion	
e law e has be ge 2 sh	Completed						autops perform	med?	death?	2 No
ral Keco ciau: The law certificate has ector, page 2 sl		25. Was case referred to medical			26.Place of Death	(Check only	1		<u> </u>	L
f Vital Physician or this certinal director	ă o	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	/ ER/Outpatient	3 DOA Other	Nursing H	lome 5 1	Residence 6	Other:	
n of Viring Physical After this		27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of In			id. Describe h	ow injury occur	red	
SiOn vittend death ctor: y the f	ă	1 X Natural 5 Pending 2 Accident Investigat	ion		1Yes 2		of Location (S	treet and Numb	per or Rural Route	Number C
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the staffer death an Director After this certificate has been signed by led in by the funeral director, page 2 should be deach staffer in the former of the f	Certification;	3 Suicide 6 Could not determine	be	home, farm, stree	t, factory, office building, e	etc. 26	or Town, St		per or Rural Route	Number, G
hou hou		4 Homicide 29a. Certifier 1 Certifying Physic (Check only	ian: To the best of my knowle r:On the basis of examination	edge, death occurr	ed at the time, date and p	lace, and due	e to the cause	e(s) and manne	er as stated. due to the cause(s)
To d withi To d	렸니	one) 2 ✓ Medical Examine 29b. Signature and title of certifier	and manner stated.		29c. License number				ned (Month, Day,)	
		DINOL	inn		O.C.M.E.			April 7, 20		
- 1		30. Name and address of person who Donna M. Vincenti, MD	completed cause of death (Ite Assistant Medical Exa		Penn Street, Baltin	nore, MD	21201			
Sta	te	31. Dan (led (Month, Day Year)	32. Registrar's Signa	ature						
Registra	_	APR 1 7 2009	week A. A.	all						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** John T. 02, 2009 5:00 P De Val April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Tate Chesapeake Hospice House Linthicum 8. Date of Birth (Month, Day, Year) April 04, 1927 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Pennsylvania 1**X** M 2□ F 81 Yrs Director <u> 180-20-9834</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it as Medical Examiner must be notified at once. Anne Arundel Severna Park 1 ☐Yes 2 ➡No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21146 548 Heavitree Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No White Specify Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Electrical Welding Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Product Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Sega Isadore De Val ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 548 Heavitree Lane Severna Park, MD 21146 Rosemarie De Val / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Our Lady Of Carbon Place) Date Our Lady Of Carbon Place | Date | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Millersville, MD 2009 4 Donation 5 DOther (Specify) Cemetery: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): RIUS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CENTER ATION AS ROVED BY MEDICAL EXAMINER be executed for M. - 1170 certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use co sibute to the cause of death? ontributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, ğ 1 □ Yes 2 0 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 W No Paraplegia due to AV Malformation in Spinal Cord, 2 🗆 No 1 ☐ Yes 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

of State

State Registrar 31. Date filed (Month, Day, Year)

ABB 0 7 2009

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

550 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

unknown

23d. Date of delivery

APRIL

24b. Were autopsy findings available prior to completion of cause of death?

2009

1 ☐ Yes 2 ☑ No

1√Yes 2□No

1. Decedent's Name (First, Middle, Last) **Physician** 2009 EKPENYONG APRIL 04 CHARLES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 20 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 € M 2 □ F 1939 NIGERIA 69 579-13-9915 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be a collined at Director MONTGOMERY SILVER SPRING MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1421 ELMGROVE CIRCLE 20905 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married BLACK altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CORRECTIONAL OFFICER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAMIE CHARLES CHARLES EKPENYONG ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. 1421 ELMGROVE CIRCLE SILVER SPRING, MARYLAND 20905 AKON CHARLES EKPENYONG/WIFE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State GATE OF HEAVEN CEME | 4/17/2009 SILVER SPRING, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MYOCARDIAL INPARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to for as a consequence of

attending physician and for use as the burial-trans certificate has been signed by the rector, page 2 should be detached funeral director. After this

Box 68760,

Division of Vital Records, P.O.

Examine Physician/Medical 2 Completed

Certification: To

29a. Certifier (Check only one)

or Attending Physician: The law requires that the death certificate be executed To the Hosping,
within 24 hours after death.
To the Funeral Director: Af Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus type 2 Asthma 24a. Was an autopsy performe 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

28d. Describe how injury occurred

D61007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHANDAGLE MD

32. Registrar's Signatur

831 E. UNIVERSITY BLVD #25 SILVER SPRING, MARYLAND 20903

State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:55p Appril 302009Year Hazel Flemming 4b. City, Town, or Location of Death Rockville 4a. Facility Name (If not institution, give street and number) 4c. County of Death Montgomery Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 20 Year 942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2**X** F Samaica 579-76-7283 66 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Rockville Montgomery 1 Yes 2 No 10f. Zip Code 20853 10g. Citizen of What Country? 10e. Street and Numbe Street 4308 Independence USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: 1 ☐Yes 2 🛛 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance 12 Data Processor 18. Mother's Name (First, Middle, Majden Surname) Geraldine Walters 17. Father's Name (First, Middle, Last) John E. Clarke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4308 Independence St. Rockville, Md 20853 19a. Informant's Name/Relationship (Type. Print) Richard L.Flemming/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐Removal from State Parklawn Mem.Pk. 4/08/2009 Rockville, Md. 4 Donation 5 ☐ Other (Specify) Funeral Service PHITATE ACCESS FINAL FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Ovarian Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Hunknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 ⊠No 1 ☐Yes 2 ☐ No 1 ☐Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) OSpice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2. XINo

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar After thi funeral of atter death
Director: /

Division of Vital Records, P.O. Box 68760,

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Examine n/Medical Certifica Medical

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25	5. Was case referred to medica
	examiner?

4 Homicide

29a. Certifier

27, Manner of Deatl 1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 □ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Docetyne Hencitchon, MIS

29c. License number 20063748 29d. Date signed (Month, Day, Year) April 9,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road Rockville, Md. Jocelyne Koudtchou MD

State Registrar 31. Date filed (Month, Day, Year) 14 APR



within 24 hours att To the Funeral Di completely filled in

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of r	viaryian	•	artment (rtificate		aith and ivi e <i>ath</i>		giene Reg. No.	0000	10000
			Decedent's Name (First, M.	iddle, Las	st)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Harold Fair	man,	Jr.						April		2009	4:55 P M
	Examin		4a. Facility Name (If not instit	ution, giv	e street and number	er)		4b. City, To	wn, or Lo	cation of Death	_	4c. Co	ounty of Death	
			Anne Arundel	Med	lical Cen	ter				polis _			Anne Ar	
	Funeral		5. Social Security Number	6. S	ex 7. ■ 7.	Age (In yrs.	last birthday)	If Under 1 Months D		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		220-38-7830		ZA IVI ZUF	67	Yrs.				Feb. 2	8,194	2 New	York
	and w	1	Usual Residence of Deceden 10a. State 10b. Con			10c. Cit	y, Town or Lo	cation			_		10	od. Inside City Limits
	/aryis	ō		e Ar	undel		Seve	rna Pa	rk					1 ☐ Yes 2 🙀 No
	the i	Director	10e. Street and Number					10f. Zip Co				10g. Citize	n of What Coun	try?
	3a or		423 Ben Oaks	Dri	ve East				21	146			USA	A
	death	Funeral	11, Marital Status		12. Was Decede Armed Force		S. 13. 1	Was Deceden		anic Origin? (Spe Mexican, Puerto	ecify Yes or No	- 14	. Race - Americ Black, White, e	
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show deet Examinat mast be recified at	ğ	1 ☐ Never Married 2 🙀 3 ☐ Widowed 4 ☐ Divo		1 []Yes 2 If Yes, Give Year or Date	Mo		1∐Yes 2∑						ite
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121	within ene.	dmo	Elementary/Secondary (0-	2)	College (1-4	or 5+)				ts Consu	ltant	Mei	rcer Inc	
d 2	filed y		17. Father's Name (First, Mic	idle, Last	4			100 100		3. Mother's Name	-			
an	d be ental ked c	To Be	Harold Fair	man,	Sr.					Grace J	. Harve	ey		
Maryland	shou ind M inar	-	19a. Informant's Name/Rela	tionship (Type. Print)		19b. Mailir	ng Address (S	Street and	Number or Rura	al Route Numb	er, City or T	Town, State, Zip	Code)
Š	alth a 27 is 27 is r tra		Suzann D. Fa	irma	n / Wife		423	Ben Oal	ks D	rive Eas	t, Seve	erna I	Park, MI	21146
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marged Exprinit of intal be refilled at once.		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremat 4 ☐ Donation 5 ☐ Other	ion 3 🗆	Removal from Sta			osition (Name natory or othe Cremat I		Apri	1 03,		ation - City or To Burnie	
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			23a. Part I. Enter the diseas	e, or com	plications that cau	sed the deat							OLIN III	Approximate Interval Between
	Physician		shock, or heart failure. Immediate Cause (Final	LIST ONLY	one cause on eac		6176	مور ہے						Onset and Death
	/Medical		disease or condition resulting in death)		a. Due to (or	as Honseq								
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<u>ita</u>	sician: The certificate rector, pag	Be (25. Was case referred to examiner?	dical					_	6. Place of Deat	h (Check only	one)		
¥ >	Physician: rthis certific ral director,	일	1 ☐ Yes 2 X No					nt 3 DOA		4 L Nursing no				y)
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Division	or At after of Direct in by	Certification:		etermined	28e. Place of	, etc. <i>(Speci</i>	fy)	reet, factory, o	JIIIUG		City or To	wn, State)	radingoi oi riule	ii i isate manber,
_	Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier (Check only one)	tifying P	hysician: To the b miner: On the bas and manne	is of examin	owledge, dea ation and/or in	th occurred at nvestigation, i	t the time	, date and place, nion, death occur	and due to the	e cause(s) a	and manner as solace, and due to	stated. the cause(s)
	To the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of co	rtifier	7			29c.	License r	umber		29d. Date	signed (Month,	Day, Year)
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	3600	Q	30. Name and address of pe	rson who	completed cause	of death (Ite	m 23a) (Type,	Print)	- M	- Ar	ann not	14 1	4 h 2	1461
	M		31, Date filed (Month, Day,	Year)	Peters 32 ARE	gistrar's Signa	ature	-101	1-10	- 715	J. St.	1 10	-11	1-1
14	Sta Registi		APR (1 6	e that						

DHMH 17 Rev 1/2001

			For Amend Items State Registrar	State, 25 Marylar	nd , g bern Cei	r tm≠21909 tificate of L	l aali h and N Death		ene g. No. 2009	12924
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medio		JOHN BRUCE	FERGUSON				Month APRIL	Day Year 2009	9:40 A M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of Death	
**			FREDERICK MEMOR			FREDERI If Under 1 Year	CK If Under 24 Hrs.	0 D-t/ Di-th	FREDERI(
	Funeral			M 2□ F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign ntry)
	Director		040-36-4414 Usual Residence of Decedent	64				March_12	. 1945Rhod	e Island
	land ow		10a. State 10b. County	10c. C	ty, Town or Lo	cation				10d. Inside City Limits
	Mary ⊢fsh	ţo	Maryland Montgomery	, Clar	ksburg					1 □Yes 2 No
	r 28a	Director	10e. Street and Number	/	RSDUIG	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	h with		14315 Sugarloaf VIs	ta Drive		20871		us	SA	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ant, the Medical Evantinat must be notified at	Funeral		Was Decedent Ever in U Armed Forces?	.S. 13.\	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White,	
9	after or ite		1 ☐ Never Married 2 🕅 Married	1 ∏Yes 2 X No If Yes, Give		☐Yes 2XINo	Specify:		Specify:	Cito.
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	filed y	ပို	17. Father's Name (First, Middle, Last)		_ Owner,		18. Mother's Name			T T T III
an	d be ental	o Be	John James Ferguson				Barbara A	anac Cra	ida	
Maryland	2 should and Mer Is marke aumatic	욘	19a. Informant's Name/Relationship (Typ		19b. Mailir				City or Town, State, Zi	p Code) 20871
	and 2		Judith K. Ferguson,	wife	1				larksburg,	
Baltimore,	- I = = =		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place			0c. Location - City or T	
ě	age ent c nt: If y or		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	**		í	/2009 11	lexandria,	Virginia
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G.	Physician	10	Immediate Cause (Final disease or condition	VIIInt	uve		120145		111	Onset and Death
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	augnes of		CERTIFICATION	/		
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387		dical	d.							
×	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23	3c. If yes, outcome of pregn	ancy				23d. Date of deliv	verv
ĕ	leath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	/		Month	Day Year
o	N requires that the d been signed by the should be detached	nysi	9 Unknown	9 Unknown						
ν. π	s that med to e deta	by P	Part II. Other significant conditions conf	tributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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ta	sician: The la certificate ha rector, page 3	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		
<u>~</u>	hysic his ce I direc		1X Yes → No	ospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	t 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Resider	nce 6 🕱Other (Spec	in operating
Division of Vital Records, P.O. Box	ng P offer t unera	:uo	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	?	28d. Describe how	w injury occurred	MOON
Sio	tendi eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
\leq	or At ifter d Sirect in by	Certification: To	4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec.	iome, farm, str ify)	eet, factory, office		City or Town,	eet and Number or Rui State)	al Route Number,
	pital ours a eral C		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	nwledne deat	occurred at the tin	ne date and place	and due to the ca	auea(e) and manner ae	etated
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical		er: On the basis of examin and manner stated.						
	ro the vithin o the	Me	29b. Signature and title of certifier			29c, License	e number	29	d. Date signed (Month	Day, Year)
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	.0		30. Name and address of person who cor		m 23a) (Type,				- (/	
	12		Shan Haide	R 315	TOI	House	Road	Fre	derick	MD 21704
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
	Registr	ar	APR 0 8 2009	Deman 1	3. pa	Kel				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **06 Physician** 1:15 am 2009 Selma Maizels Gratz April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery 5600 Wisconsin Avenue, #208 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months. Days Hours 1 ☐ M 2 🗷 F 91 Director 220-09-3743 October 05, 1917 District of Columbia Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show he notified at 1 ☐ Yes 2 TRING Director Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a 20815 5600 Wisconsin Avenue, #208 event, the Medical Exercitor coust Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "" any injury or other traum"." 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 😿 No 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygienist 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Aaron Maizels Rose Belasko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gratz - Son 7615 Persimmon Tree Lane, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Bemoval from State 4 □ Domation 5 □ Other (Spegfy) King David Memorial Cardens 04/08/2009 Falls Church, Virginia 21. Sign ture of Fune at Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Jak 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hilling. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Examl Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 9 Unknown Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Aortic Stenosis 1 ☐ Yes 2 x No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an **Asthma** autopsy 1 ☐ Yes 2 🛣 No Diabetes Mellitus 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours after ne Funeral Dire pletely filled in b 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD0014111 April 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, Suite 800, Chevy Chase, Maryland 20815 Jerome Putnam, M.D., 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 08 2009 Registrar

Physician Jeanne D. /Medical **Examiner** Suburban Hospital 579-14-8791 6. Sex **Funeral** 1 □ M 2 🔽 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Montgomery Director 10e. Street and Number 6505 Stoneham Rd. Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 3 □ Widowed 4 □ Divorced Completed Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other th: any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) Be Jacob Decker ပ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burnal-transit P.O. Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 Unknown Completed by Division of Vital 25. Was case referred to medical examiner? Be GOREN, JEANNE 1 Yes 2 No 27. Manner of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apronth Zay 2009 9:45 P.M GOREN 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda 8. Date of Birth (Month Day, 9. Birthplace (State or Foreign Ohio If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Days Hours Min T920 88 Yrs. 10c. City, Town or Location 10d. Inside City Limits Bethesda 1 ∐ Yes 2**V**∑ No 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20817 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 □Yes 2 No If Yes, Give Year or Dates Specify. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Goldie (unknown) 19a. Informant's Name/Relationship (Type. Print)
Barbara Needleman / daughter 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 10738 Normandie Farm Dr., Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Kling David Mem. Garden Apr. 7, 2009 Falls Church, VA 22. Name and Address of Facility Torchinsky Tebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a, Part 1, Enter the disease, or complications that yoused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 □Xuatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) April 5, 2009 29b. Signature and title of certifier 29c. License number D66304 Sujoy Ghosh Tagore, MD 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year, 32 Registrar's Signature 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 🎵 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year April 13, 1:09 P_M **Physician** Ritchie Downs Gibson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, December 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1, 1965 Months Days Min. 11 M 2 □ F 43 Maryland ٧rs 213-76-4483 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Extending Du 100 libed at once. 10a. State 1 ☐ Yes 2 No St. Mary's Clements Maryland Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20624 USA 39120 Yates Road 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☒ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Home Construction College (1-4or 5+) Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Jackson Gibson Mildred Downs ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 39120 Yates Road Clements, MD 20624 Ritchie Lee Gibson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 18 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland 2009 Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fune of Service Mattingley-Gardiner Funeral Home, F P.O. Box 270 Leonardtown, MD 20650 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ihour **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 9 | Unknown 9 Unknown been signed by i should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 2 🔲 No 1 🗌 Yes 24a. Was an certificate has b irector, page 2 sh autops, performed 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 20 ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient Certification: To After this funeral 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident neral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a The physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date siggred (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Downs Gibson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

James C Boyd, M.D. 41,680 Bessie Drive Ste. 301 Leonardtown, MD 20650 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G894 8/04/09 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 Month 9:45 PM **Physician** George Frederick Gass April 13, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 16, 19 5252al Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220-10-5929 1⊠M 2□F 8 Yrs Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Abell 1 ☐ Yes 2 No St.Mary's Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20606 USA 38674 Morris Point Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Supply Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Howard Gass Lola Lee Hayden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 43350 St. John's Road Hollywood, MD 20636 Lillian G. Goldsborough / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 18, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 Jard 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCIEROTIC CARHOVACCULAR DIFFACE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): LYMPHONER VEALS Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director, page 2 should be detached for use as the temporal pages. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ PANCYTOPENIA 1 ☐ Yes 2 ☐ ₩o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D560 96 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASSOCIATES LEONARD TOWN 20650. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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	/Media		TAMMY L.		AGHER						APRIL	6	2009	6:	15 A M
4	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal 10153 Shelldrake Circle Damascus						Death			4c. County of Death Montgomery			
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under 2		8. Date of Birth	L	9. Birth	olace (Sta	te or Foreign
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003	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exactive the Indiffed at		3 Widowed 4 Divorced	If Yes, Gi Year or D	Dates:										
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Maryland 21215-0036	2 sho		19a, Informant's Name/Relationsh		Enchand						Route Number e, Dama			Code) 2087	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Evertinal terrutal terrutified at once.		Dean D. Galla 20a. Method of Disposition	agner / n		lace of Dispo			ine C			20c. Location			
Baltimore,	ages ant of t: If it y or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	emetery, crer	natory or othe	er place)					-		
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Ö	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□ Unkn		eatii 5	Other (spec	ny)							
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the xaminer: On the b and man	e best of my know asis of examinat ner stated.	wledge, death tion and/or inv	occurred at restigation, in	the time, my opin	, date and nion, death	place, ar occurre	nd due to the ca d at the time, da	use(s) and m te and place,	anner as s and due to	tated. the caus	ə(s)
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	10		30. Name and address of person w Christopher I					omer	cy Av	e.,	Rockvil	le, Md	. 20	850	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} 2009 2030 14 April Evelyn Thompson Griffith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Rock Springs Village Assisted Living Forest Hill Forest nlll

If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

SEPT 20, 1912 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F Months Maryland Director 96 216-07-2654 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Pages 1 and 2 should be med whom to the state of Health and Mental Hygiene ment of Health and Mental Hygiene tant: If Item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Harford Forest Hill Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 United States 1 Colgate Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify Specify: 9 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Leon Thompson Annie Marcus 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1311 Gunston Road, Bel Air, MD 21015 Ruth A. Bedsaul/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Friends Burial
Ground 20c. Location - City or Town, State Apri $\overset{\text{Pate}}{1}$ 7. 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o Important: If i any injury or once. 2009 Calvert, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years PULMONARY FIBROSIS **Physician** /Medical Due to (or as a consequence In) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760. physician use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown ۵. s been signed b should be deta 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by MELLITUS DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autonsy The performed? certificate 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No Vital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living examiner? 1 | Yes 2 1 | 1 | Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide 1 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ATTENDING DHY SICION DO 21207 APRIL ISTH 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MIDCREST CT. BACTIMORE, MD 21286 FRANZ C. VELLA- CAMILLERI 17.0 31. Date filed (Month, Day, Year) 32. Regj≰trar's Signature State Registrar

DK.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month APRIL 2009 **Physician** 6 8:40 A DORA VIRGINIA HURLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5220-60-0048 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 228-09-1263 Director 92 May 11, 1916 Tennessee Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Dickerson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20842 19245 Martinsburg Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify: White altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be မ James Isaac Rambo <u>Susan Isabell Johnson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Heath Important: If item 27 any Injury or other tra 19245 Martinsburg Road, Dickerson, Maryland Belva Bower, daughter-in-law 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Macedonia Baptist Cemetery Chilhowie, Virginia 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature Januaral Sarvice Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immenate Cause (Final diseas or condition resulting in death) Ulmong Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uncease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe this certificate 2 **UN**O 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 📴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

10

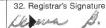
State Registrar

DHMH 17 Rev 1/2001

Sandeep Sharma, MD,

31. Date filed (Month, Day, Year) APR U & ZUUS

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, Maryland

D0064624

April 6, 2008

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State of Maryland /	Department	of Health	and	Mental	Hygiene	E

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	Physici		1, Decedent's Name (First, Middle, Last)	FREY (GILBER	RT HIGGIN	S	2. Date Mon Apri	of Death	2009 2009	3. Time of Death 2 8:55 AM	
A	/Medio Examir		4a. Facility Name (If not institution, give street and number, Kline Hospice House)		4b. City, Town, o		of Death	4	c. County of Deat		
	Funeral Director		5. Social Security Number 6. Sex 7. A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ge (In yrs. las		If Under 1 Year Months Days	-	24 Hrs. 8. Date Min. Nov.	of Birth ith, Day, Yea	9. Bird 949 Wes	hplace <i>(State or Foreign</i> untry) ct Virginia	
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	e Mary ka-f sh tified a	ctor	Maryland Washington	Brow	vnsvil	.1e					1X Yes 2 □ No	
	h with th 23a or 28 st be no	Funeral Director	10e. Street and Number 2348 Bateler Road			10f. Zip Code 2171	5		10g. (Citizen of What Co	untry?	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 1 Ves 2 Married 3 Widowed 4 Divorced	?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	lispanic Or an, Mexica Specify:		or No-	14. Race - Ame Black, Whit Specify:		
21215-0036	d within 72 hou giene. r than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman					16b. Kind of Business/Industry		
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	s 1 and 2 of Health s item 27 is other tra		Joan Hendrickson / Sister			Monocacy						
lore	e = c		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	*		sition (Name of matory or other pla		Date 4/7/09		Location - City or		
Baltimore,	permit. Pa Departmer Important: any injury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Smit	RO	g Cremat Name and Addre DBERT E. O1 NORTH	ory ess of Facili DAILE	Y & SON	FUNERA	L HOMES,	P.A.	
			23a. Part1. Enter the disease, or complications the cause shock, or heart failure. List only one cause or each	the teath.						DERICK,	Approximate Interval Between	
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	Examiner		Hu	s a conseque	a i						HOURS	
	uted I unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events causing doubt) lect	a conseque	tovu	Fail	ure				Hours	
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.O. Box 68	The law requires that the death certificate has been signed by the attending playee 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant in the past 10 months?	2 Fetal o	death 3	⊒Ectopic pregnanc ⊒ Other <i>(sp</i> ec <i>ify)</i> _	у			23d. Date of de Month	ivery Day Year	
Δ.	w requires that i been signed by should be deta	by	Bladder ocine and committee of the control of the c							23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 ☐ No 3 ☐ Probably 4 ☐ Unknown		
Division or Vital Records,		Completed							Was an autopsy performed Yes 2	prior to death?	utopsy findings available completion of cause of 2 ☐ No	
Vita	Physician: The this certificate all director, pag	Be	25. Was case referred to medical examiner? 1. The second of the second			_ lott	2000	e of Death (Check				
on or	ing Phy. After this uneral di	tion: To	1 ☐ Yes 25 No Trospital. 1 ☐ Inpat 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, D) C ☐ Accident investigation		R/Outpatier 28b. Time o Injury	f 28c. Inju	4 K	28d. Des		6 □Other (Spe	cify)	
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	To the Hospital or Atter within 24 hours after des To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination								
_	To the To the Comp	Me	29b. Signature and title of certifier			29c. Licens				Date signed (Moni		
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3_	-1			mas Jo	hnson	Print) Drive,	Suite	200, Fr	ederic	k, MD 21	702	
	Sta Regist	_	31. Date filed (Month, Day, Year) 32. Regis	trar's Signatu	d.	arked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 2933 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** April 6. 2009 3:45 William Anthony Haag, Sr. /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney If Under 1 Year | If Under 24 Hrs. <u> Montgomery General Hospital</u> Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year) Min. 1 X M 2 □ F Months Days Hours 80 Director 577-34-1352 Nov. 15. 1928 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 10a State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Moden Examiner must be notified at 1 □ Yes 2 X No Director Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11402 Meadowlark Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Saltimore, Maryland 21215-0036 1 □ Yes 2 🕅 No Specify. If Yes, Give Year or Dates: 1951-52 þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene.
7 is marked other than "n. United States Govt. Elementary/Secondary (0-12) College (1-4or 5+) 12 Offset Pressman Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked o any hijury or other trainment one. ဂ Henry Sylvester Haag, Sr. Antoinette Raab 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11402 Meadowlark Drive, Ijamsville, Maryland William A. Haag, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 21. Signature of Pineral Service Cicenses 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus disease of condit (Final Sepsis

Due to (or as a consequence of): Se **Physician** resulting in /Medical Examiner Cou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed ou ces burial-transi and Due to (or es a consequence of) Box 68760, attending physician Physician/Medical req ires that the death certificate the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the de ached 9 Hinknown 9 Unknown signed by 1 3 be de ach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed peer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1/10 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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12+1

DHMH 17 Rev 1/2001

State Registrar

Medical

29a, Certifier (Check only one)

Vladim**i**r Rakhmanin.

29b. Signature and title of certifier

MD. Registrar's Signature Backer

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Prince Philip Drive, Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Baltimore, Maryland 21215-0036

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			For State	State of Maryland				Mental Hyg	jiene	
			Registrar		Cei	tificate of	Death	2. Date of Dea	leg. No. 2 0 0 9	2934
н	Physici	an	1. Decedent's Name (First, Middle, Last) WILLIS	TT A	DDTC			Month	Day Year	M
1	/Medic		4a. Facility Name (If not institution, give si		RRIS	4b. City. Town, o	r Location of Death	APRIL	1 2009 4c. County of Dea	5:11 P ™
	Examin	er	SOUTHERN MARYLAND			CLINT			PRINCE G	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		rthplace (State or Foreign ountry)
	Director		5//-62-/253	61	Yrs.			MAY 19		SHINGTON, DC
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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	r dea	nuel	11. Warta States	Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine must be notified an once.	Š	1 Never Married 2 Married 3 Widowed 4 Noverced	1 □Yes 2 ☑ No If Yes, Give Year or Dates:		□Yes 2¶ No			Specify:	BLACK
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b	filed II Hyg other	BeC	17. Father's Name (First, Middle, Last)	I III	COLIE	OILK BIL		e (First, Middle,	Maiden Surname)	
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Maryland	2 sho and is ma	ľ	19a. Informant's Name/Relationship (Typ		1				r, City or Town, State,	
	1 and 2 Health em 27 i		WILLIAM HARRIS/BRO					Date UPPER I	1ARLBORO, MA	ARYLAND 20772
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Baltimore,	permit. Page Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ■ Conse	RESU		. Name and Addre	TERY 4/11	· 1	CLINTON,MA KINS FUNER	
Ba	permit. Departr Importa any Inju								ER, MARYLAN	
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
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687	ng ph as th	Physician/Medical	IF FEMALE:							
Box	ath ce ittendi or use	ian/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal	death 3[Ectopic pregnanc	су		23d. Date of d Month	elivery Day Year
o.	he de r the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of do 9 ☐ Unknown	eath 5L	Other (specify) _				,
σ.	res that the de signed by the a be detached to		Part II. Other significant conditions conf		Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
of Vital Records,	quires n sigr ald be	d by	GASTRIC	CANCER				1 □ Y	es 2 No 3 I	Probably 4 Unknown
တ္တ	aw requir is been s 2 should	Completed						24a. Was a	an 24b. Were a	autopsy findings available
B	The law ate has page 2 s	mo						autop perfor 1 □ Yes	med? death?	
/ita	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea			
7	ohysio this o al dire		1 Yes 2 No H			IL 3 DOA			ence 6 Other (Sp	ecify)
n C	ding Physician: The h. After this certificate h funeral director, page	ion	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat rk?]Yes 2 ∐No	28d. Describe h	ow injury occurred	
Division	l or Attendi after death. Director: A	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, str		162 2 100	28f. Location (S	treet and Number or I	Rural Route Number,
<u>≥</u>	salor / s after al Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Specify)			City or Tow		,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (sician: To the best of my knowner: On the basis of examinat and manner stated.						
	To th withir To th comp	Me	29b. Signature and litle of certifier			29c. Licens	se number		29d. Date signed Mon	nth Day, Year)
	4		▶ Venlet	M)53885		4/2	12009
_	81		30. Name and address of person who con	mpleted cause of death (Item FUM 750 I	23a) (Type,	LA775	ROAD #	307 C	UNTON M	12009 D 20735

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of IVI	arylana		rtificate of				Reg. I			ł f.m.,	
ı			Decedent's Name (First, Middle,	Last)					2.	Date of D		Day	Year	3. Time of	Death
	Physicia /Medic		Mary Ida Jancar						AŢ	ri1		2009	Teal	4:30	A^{M}
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of	Death		4	4c. County of	of Death		
			Northampton Man	or Nursing	Home ge (In yrs. las	t hirthday)	Frederic If Under 1 Year	k If Under 24	1 Hrs. To	Data of E]	Freder		nlana (Ctata a	
	Funeral Director		5. Social Security Number 216-12-2743	6. Sex 7. Ag 1 ☐ M 2 🛣 F		Yrs.	Months Days			Date of E			Coul		or Foreign
			Usual Residence of Decedent		87				J	une	18,	1921 1	Mary	land	
	yland how		10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside Ci	
	a-fs	ctor	Maryland Frederi	.ck	Frede	rick								1 ☐ Yes	2 No
	or 28	Directo	10e. Street and Number				10f. Zip Code				10g.	Citizen of W	hat Cour	ntry?	
	23a		5679 Barberry Co				21703				USA	Ą			
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Merical Extr. it are roughed at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican, I	n? (Specif Puerto Ric	y Yes or Nan, etc.)	No-		- Americ , White,	can Indian, etc.	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	ed 1 ∏Yes 2 🔼 If Yes, Give Year or Dates:	No		1 □Yes 2X No	Specify:				Specify:	r 11		
Ş	thou		15. Decedent's	s Education		16a. Dece	dent's Usual Occup	ation			16b.	Kind of Bus	Wh1t iness/In	-	
21215-0036	should be filed within 72 and Mental Hygiene. s marked other than "nai umatic event, the Merfe	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or !	5+1	(Give life. l	kind of work done of DO NOT use retired	during most o d)	of working						
2	d with	Som	12	College (1 401 c	· .	omema	ıker				owi	n_home			
ng	e file tal Hy d oth	Be (17. Father's Name (First, Middle, L.	ast)				18. Mother's	s Name (F	irst, Midd	le, Maid	en Surn a me)		
Maryland	Meni Meni arkec	၉	Dewey Bissett					Helen	Eliza	abeth	Her	nderso	n		
<u>a</u>	2 sho 2 sho is m raum		19a. Informant's Name/Relationshi	ip (Type. Print)		19b. Mailir	ng Address (Street	and Number	or Rural F	Route Nun	nber, Cit	y or Town, S	State, Zip	o Code)	
	es 1 and 2 should be filed of the death and Mental Hygin fitem 27 is marked other ir other traumatic event, it		Adam Parker, per 20a. Method of Disposition	sonal rep.					ct, C			Mary]			5
Baltimore,	Pages nent of I int: If ite		1 XBurial 2 ☐ Cremation 3	3 ☐ Removal from State	_ I		sition (Name of natory or other plac						•		
	it. Partmen		4 □ Donation 5 □ Other (Special II)		Gate		eaven Cen								
g	permit, Pages Department of Important: If it any injury or c		21. Signature of Juneral Service L	icensee			2. Name and Addre								ноте
			23a. Par I. Enter the disease, or c	complications that caused	d the death.							riaryra	and	Approximate Interval Bet	e
	Dhuaisian		s ock, or part failure. List o	nly one cause og each li	ne. PSIS		,	3,		,	,			Interval Bet Onset and I	ween Death
	Physician / /Medical		diseas or cond ion resulting do h)	a. Due to (or as		nce of):							- 4	MYS	
	Examiner				EUMO		-							DAYS	
	T #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unleaded or Injury	Due to (or as	a conseque	nce of):									
	nd nd ransi	Examiner	that initiated events resulting in death) Last	c											
Š,	e exe		resulting in death) Last	Due to (or as	a conseque	nce of):									
68/60,	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medical	•	d									_		
	ding page as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	**/									
ŏ n	eath cer attendir for use	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal d	eath 3	Ectopic pregnanc Other (specify)	y				23d. Date Mon		,	Year
j	the d	ysic	1 □Yes 2 🛛 No 9 □ Unknown	9 Unknown	at time of dea	J.L									
J	w requires that the de been signed by the should be detached		Part II. Other significant condition	s contributing to death b	out not resulti	ng in the u	nderlying cause giv	en in Part I.		23e. Dio	d tobacc	o use contril	bute to t	he cause of d	leath?
ecords,	quires n sign	d by	MYELOPA	HHY OF	T6	·				1 🗆	Yes	2 □ No 3	3 ☐ Prot	bably 🙀	Jnknown
ပ္ပ	S T 8	Completed		/						24a. Wa		24b. W	ere auto	psy findings	available
Ĕ	The la ate has	mo							_	pei	formed	? de	eath?	mpletion of ca	ause of
VItal	ician: The lav certificate has ector, page 2.	ø	25. Was case referred to medical			 		26. Place o	of Death (0	1 ☐ Yes Check only		NO 1	∟Yes	2 □ No	
	Physician: r this certific ral director,	ල ප	examiner? 1∐Yes 2 X No	Hospital: 1 ☐ Inpati	ent 2 🗆 EF	R/Outpatier	nt 3 DOA Oth	er: 4 🔀 Nurs	ing Home	5 □ Re	sidence	6 □Othe	r (Specii	fy)	
n 01	ng Pt fter tr neral	T:U	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 2 ay, Year)	8b. Time of Injury	28c. Injur Worl					jury occurre			
UIVISION	eath. or: A the fu	catic	2 ☐ Accident investiga	ation			M 1 🗆	Yes 2 □ No							
≌	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Inj building, et	ury - At hom c. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f	Location City or T	(Street own, St	and Numbe ate)	r or Rura	al Route Num	ber,
2	urs a urs a aral D		OOo Cortifier 4M Contified on	Dhualalan, Taitha haat	-f l		h		-1	-1 -1 - 4 - 48		-/->			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)	Physician: To the best examiner: On the basis of and manner st	of examinatio	eage, aeat n and/or in	vestigation, in my c	me, date and opinion, death	piace, and occurred	at the tim	e, date	e(s) and mar and place, a	nd due to	stated. o the cause(s)
	omple	Mec	29b. Signature and title of certifier	and manner st			29c. Licens	e number			29d.	Date signed	(Month,	Day, Year)	
	F>F0		•	V-			D62223	!			A ===	41 6	200	0	
	8		30. Name and address of person w	no completed cause of c	death (Item 2	3a) (Type					Apr	il 6,	200	J	
				4	,	F - 1									
			Praveen K. Bolan	rum, MD, 19	6 Thom	as Jo	hnson Dr	ive. S	uite	230-	Fre	ederic	k. M	m 217	'02
	Star Registra		Praveen K. Bolan 31. Date filed (Month, Day, Year) APR 08	00 04 -:	6 Thom rar's Signatur			ive, S	uite	230,	Fre	deric	k, M	ID 217	02

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 2009 /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RHOWK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. | Oct 1 0 1933 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number . Age (In yrs. last birthday, **Funeral** 1**X** M 2□ F 216-30-5627 75 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Rock Hall 1 Yes 2 No MD Kent Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21661 21281 Chesapeake Ave. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: -1957 1 ☐ Yes 2 No Specify White δ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 Is marked other th: any hiury or other traumatic event, Their once. Manager Business Forms 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Franklin Jacob Fannie Wickes Willson ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Hays (daughter) 826 Dixon Dr. Stevensville, MD. 21666 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 4/18/09 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) mery Service License 22. Name and Address of Facility Galena Funeral Home of Stephen L. 21. Signat M00510 118 West Cross St. Galena, MD. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, speck or hear, failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death **Physician** /Medical Due to (or es a conse suence of): Examiner reloro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as, a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 ☐ Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

filled in by the funeral after death Director: 24 hours a within 2

> State Registrar

ical

29a. Certifier (Check only one)

29b. Signature and title of certifier

140

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 March 28, 1145 AM M David H. Kay 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Months Hours Cour DC 8/6/1940 68 215-38-7072 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No Silver Spring MD Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20906 United States 3100 North Leisure World Blvd #302 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. ∐Yes 2 ∐XNo 1 Never Married X Married 1 □Yes 2 🕱No If Yes, Give Year or Dates: Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Kay Sarah Gertrude Kaplin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 North Leisure World Blvd #302 Silver Spring MD Janet D. Kay - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/30/09 4 Donation 5 Other (Specify) Judean Mem. Gardens Olney, MD 22. Name and Address of Facility
Edward Sage! Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee Malle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final peration precumo mid disease or condition resulting in death) Due to (or as a consequence of Kinson's if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

be executed

Box 68760,

P.O.

Records,

of Vital

Division

Physician:

certificate has

After this

death.

To the Hospital o within 24 hours af To the Funeral DI completely filled in

Department of Health a Important: If Item 27 is any injury or other traconce.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

death with

72 hours after

\$\frac{1}{2}\$ should be filed within \$\frac{7}{2}\$ th and Mental Hygiene.
7 is marked other than "n.

Pages 1 and 2 should

3altimore, Maryland 21215-0036

Examine Physician/Medical à

attending physician and for use as the burial-transi signed by the a s peen s Completed page 2 director, Be Certification: To funeral spital or Attendinours after death.

neral Director: A

IF FEMALE:

2 No 1∏Yes 27. Manner of Death 1 ☑ Natural

5 Pending investigation

1 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28h Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

30. Name and add/ess/of r Vladimir/M. of person who completed cause of

erson who completed cause of death (Item 23a) (Type, Print) Rakhmanin MD 18101 Prince Philip Drive Olney MD 20832

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of eartifier

08 2009

6 ☐ Could not be

determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Mary	-	artment of I		nd Mental Hy	giene Reg. No. 2	00 12030
	Dhariai		1. Decedent's Name (First, Middle	, Last)				2. Date of De	ath	3. Time of Death
	Physici /Medio		Helen Anna	King				Month April	9, 2	^{Year} 10:30P ^M
	Examin	ner	4a. Facility Name (If not institution			4b. City, Town, o		Death	4c. County	
~′_			16411 Brandyw 5. Social Security Number		yrs. last birthday)	Brand If Under 1 Year	dywine	Hre la Data de Bir		Georges
	Funeral Director		224-28-1628	1 □ M 2 X F 9		Months Days		Min. August	th 27, 1917	9. Birthplace (State or Foreign Country) Washington, DC
			Usual Residence of Decedent						,	8
relya	show	-	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits
ho M.	28a-f	ectc		Georges	Brandyw					1 □Yes Z No
diw.	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be recitied at once.	Funeral Director	10e. Street and Number 16411 Brandywir	ne Rd.		10f. Zip Code 206	513	İ	10g. Citizen of W	√hat Country?
t to ob	ms 2	nera	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of F	lispanic Origin	n? (Specify Yes or No ⊇uerto Rican, etc.)		e - American Indian,
စ္က	or ite		1 ☐ Never Married 2 ☐ Marri	Armed Forces? 1 □ Yes 2 □ No If Yes, Give		ifYes, specify Cub. 1 □Yes 2 🛂 No	an, Mexican, F Specify:	Puerto Rican, etc.)		k, White, etc. White
	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:					Specify	•
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Z 1Z	r thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		erk	u)		reactar	Government
and,	al Hyg	Be C	17. Father's Name (First, Middle, L				18. Mother's	Name (First, Middle,	Maiden Surnam	θ)
Na Par	Ment arked atic e	2	Herbert Pete	rs			Ann	a Keifer		
Mar	h and		19a. Informant's Name/Relationsh		l l			or Rural Route Numb		
a , -	Healt em 2 other		Joan Kratko/Gu 20a. Method of Disposition		0b. Place of Dispo		ine Rd	., Brandyw		20613 City or Town, State
TIOI Pages	ent of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State	cemetery cres	natory or other place Ld–Echols	Crem.	April 11		te Hall, MD
Dalumor	oortar injur		21 Signature of Funeral Service L	0.	4		1			
מֿ מֿ	Depar Impor		Dangton C	_ ackols	3	BRINSFIEL 0195 Thre	LD - EC	HOLS FUNER	RAL HOME	,P.A. Hall.MD 20622
			23a. Part 1. Ent in he disease, or o shock, or heart failure. List o	complications that caused the	d th. Do not ent	er the mode of dyir	ng, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	-a END 57461	E ALZI	HEIMER'S	Dist	FASE		Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a cor			7,5	7 10 1-1		
		<u>.</u>	Sequentially list conditions,	b	man thanks the					
nted	ansit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	One to for all 3 late	tencularate cry.					
exec	an and rial-tra		that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
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ertific	ling pl	Med	IF FEMALE:							
atho	attending properties of the second se	Physician/Me	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of pro	Fetal death 3 [Ectopic pregnanc	у		23d. Date Mor	e of delivery nth Day Year
the de	ned by the a	ysic	1 □ Yes 2 ☑No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5L	Other (specify) _			INIO	nn Day Tour
that	ned by		Part II. Other significant condition	ns contributing to death but not	t resulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco use contri	ibute to the cause of death?
quires	en sign uld be	ed by						1 🗆 \	res 212 No	3 ☐ Probably 4 ☐ Unknown
aw re	as been s 2 should	Completed						24a. Was		Vere autopsy findings available
The	page	mo							rmed? d	rior to completion of cause of leath? □Yes 2 □No
clan:	nis certificate director, pago		25. Was case referred to medical examiner?				26. Place of	1 ∐Yes Death (Check only o		Lifes 2 Lino
hysi	this c	၉	1 Yes 2 XNo		2 ER/Outpatien		4 LI Nursii	ng Home 5 🔀 Resid	lence 6 ☐ Othe	er (Specify)
ding	h. After funer	io	27. Marurer of Death 1 V Natural 5 ☐ Pending		ar) 28b. Time of Injury	28c. Injur Work		28d. Describe h	ow injury occurre	d
Attend	death ctor: y the	licat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be	At home farm stre		Yes 2 □ No	28f Location (6	Street and Number	er or Rural Route Number,
2 5	after Dire d in b	Certification:	4 ☐ Homicide determin	building, etc. (Sp	pecify)	ot, lactory, onloc		City or Tow	in, State)	7 Of Hurar House Number,
ospita	hours unera ly fille		29a. Certifier 1 Certifying	Physician: To the best of my	knowledge, death	occurred at the tir	ne, date and p	place, and due to the	cause(s) and mai	nner as stated.
the H	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	one)	xaminer: On the basis of exar and manner stated.	mination and/or inv	estigation, in my o	pinion, death	occurred at the time,	date and place, a	nd due to the cause(s)
10	To con	2	29b. Signature and title of certifier	, MD		29c. License			29d. Date signed	(Month, Day, Year)
/			· amprisone			21661	7		April 1	1, 2009
5	4		30. Name and address of person w	ho completed cause of death ((Item 23a) (Type, F	Print) SOUAN	E DR	NOTTIAL	CHAM A	11, 2009 MD . 21236
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	200	- 2/	17/00	, ,	
	Registra		APR 13:	2009	A. 100	alla de				

Registrar
DHMH 17 Rev 1/2001

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regory Lloyd K		1- For State Certificat	nt of Health and Mental I e of Death	Reg	
Physicia Medical Exami	31112	1. Decedent's Name (First, Middle,Last) Gregory Lloyd	Kemp	2. Date of Death Month D April 14, 200	3. Time of Death 4 / 15 / 20 0 90905 hrs
		4a. Facility Name (if not institution, give street and number) 18 South Mechanic Street Apt. # 4	4b. City, Town, or Location of Dea		4c. County of Death Allegany
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdom) 212–80–9584 1X M 2 F 47		8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
daryland 28a-f show	tor	MD Allegany 10e. Street and Number	Cumberland	100	1 X Yes 2 No Citizen of What Country?
with the Maryland ns 23a or 28a-f sho	Director	18 South Mechanic Street, Apt #4	21502		USA
215-0036 be filed within 72 hours after death with the Maryland mial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funera	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.
urs after tural", tminer	ক্র		1 Yes 2 No specify: cedent's Usual Occupation (Give kind of		Specify: White 6b. Kind of Business/Industry
11215-0036 Id be filed within 72 hours a fental Hygiene. tarked other than "natura event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use r Contractor	etired)	Construction
15-0036 filed within 72 Hygiene d other than ', the Medical	Som	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Lloyd Junior Kem			Belle Leasure
MD 2 nd 2 shoul alth and M m 27 is m	To		Mailing Address (Street and Number of 2017 Messick Road)		
Baltimore, MD 212 permit. Pages I and 2 should b Department of Health and Ment Important: If item 27 is markinjury or other traumatie even		1 Burial 2 X Cremation 3 Removal from State crematory	Disposition (Name of cemetery, or other place)		20c. Location - City or Town, State Cumberland, MD
Saltir emit. F bepartme mportal ijury ol		P1. ig ature of Funeral Service Ligensee			y uneral Home, P.A.
Physician	\dashv	23a. Part - Enter the diserve, or complications that caused the death. Do not experience the death of the death of the death.	404 Decatur Stree		t, shock, or heart Approximate Interval
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	e, hydrocodone) in	ntoxicatio	Between Onset and Death
1	Ļ	Sequentially list conditions, b	and cocarne use		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
cuted and transit		dd.	5 No. 100	2 /00 mm	
50, te be executed sysician and burial - transit	edical	X UNPENDED AMENDED 23a, 27, 28a— IF FEMALE: 23c. If yes, outcome of pregnancy	f,perME, g890 4/2	3/09 11	23d. Date of delivery
OX 687(leath certifica e attending ph	sician/l	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	Fetal death 3 Ectopic pre-	gnancy	Month Day Year
O. E hat the ded by the letached	by Phy	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.		acco use contribute to the cause of death? 2 No 3 Probably 4 ✔ Unknown
ords, P	ted t				24b. Were autopsy findings available
ecor ne law ra te has bo ige 2 sho	Completed			autopsy perform	ed? death?
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Che	ck only one)	
n of Vit ding Physic After this	ပ	1 ✓ Yes 2 No Inpatient 2 ER/Outs 27. Manner of Death 28a. Date of Injury 28b. Tir	patient 3 DOA Other Number of Injury 28c. Injury at Work?		esidence 6 🗹 Other: Scene w injury occurred
ion C tending leath. for: Af the fun	ation	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 4/15/09 Fd	9:05 am 1 Yes 2 X No	unk	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. teral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 X Could not be determined Specify residence	n, street, factory, office building, etc.	28f. Location (Str or Town, Sta Cumberal	reet and Number or Rural Route Number, City te) 18 S. Mechanic St and, MD
To the Host within 24 hd To the Funcompletely	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner:On the basis of examination and/or inv			
To To COI	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		April 16, 2009
			enn Street, Baltimore, MD 21	201	
Si Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 2 2009 32. Refistrar's Signature	ball		
DHMH 17 Rev 1/2			SINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BRENDA SUSSETTE KYLE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARLES ENTER MATA IVISTA MEDICAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Years 3-26-1953 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🗶 F 56 WASHINGTON, D.C. 220-62-5132 Yrs Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Examiner must be notified at Director 1 ☐ Yes 2√∑ No MD. CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event. 1000 ALLWARD DRIVE 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: WHITE 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOT. TEACHED KINDEDCAPE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACK FAIRFAX DAYOFF JOYCE DE MOUTH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS KYLE - SPOUSE WALDORF, MD. 1000 ALLWARD DRIVE 20602 ore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MD. VETERANS CEM. 4-22-09 CHELTENHAM, MD. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee MQ0479 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ି _ସPhysician /Medical Due to (or as)a consequence of): Examiner ulmowar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (dras a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 5 Other (specify) P.0. the 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part I// Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by NO (2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform certificate 1 □Yes 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical director, Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes⁄ 2 No BED DOA After this c funeral dire 1 Dipatient 2 ER/Outpatient 28a. Date of Injury (Month, Day, Year) 27. M. n r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 ☐Yes 2 ☐ No · death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my kn wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examilation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title of certifier 29c. License number 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) ong Chon Medical (enna 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:30AM **Physician** LAUKHUFF APLIC MARY 200 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner TORK AKKTON ALTIMORE If Under 1 Year 6. Sex 8. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 187-18-4339 86 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haatth and Mental Hygiene.
Intern 27 is marked other than "natural", or frems 23s or 28s-f show 10a. State 10c. City Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No BALTWORK **Funeral Director** ALKTON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21120 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yes X No Baltimore, Maryland 21215-0020 Specify Completed by 3 Widowed 4 ☐ Divorced WHI Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be JUTER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DROWN other 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ■ Removal from State Department of Important: If any injury or MELLINGER MERMANITE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): by Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760,公 Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobaccoose contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this cartificate hes been signed by the funeral diractor, page 2 should be detached 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy performed? 1 🗆 Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours of To the Funeral D completely filled is 29a. Certifier edicai 1 🖰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 882 30. Name end address of person who completed cause of death (Item 23e) (Type Print) 31. Date filed (Month, Day, Year) State APR 2 2 2009 Registrar

7. Age (In yrs. last birthday)

73

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Mary Louise Mattingly

April

Min.

2. Date of Death

8. Date of Birth (Month, Day, May 13,

May

12,

3. Time of Death P_M 4:45

4a. Facility Name (If not institution, give street and number) 24155 Mattingly-Latham Road

5. Social Security Number

4b. City, Town, or Location of Death Chaptico

Days

If Under 1 Year | If Under 24 Hrs.

Hours

Day 2009 4c. County of Death St. Mary's

Funeral Director

28a-f show

the Maryland

e filed within 72 hours after death with tal Hygiene.

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

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and 2 should be ntal h and Menta

permit. Pages 1 and 2.
Department of Health an.
Important: If Item 27 is m.
any injury or other

Physician

/Medical Examiner

> burial-transi and

attending physician for use as the buria

signed by the ar

After this certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical

2

Completed

Be

2

Certification:

Medical

27 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Madical Expressions rust be redified at Director Funeral \$ Completed Be

217-80-6266 Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number

St. Mary's

6. Sex

1 □ M 2 🖾 F

10c. City, Town or Location

Months

Chaptico 10f. Zip Code

1 Yes 2K No 10g. Citizen of What Country?

Maryland

9. Birthplace (State or Foreign

10d. Inside City Limits

24155 Mattingly-Latham Road 11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 No Specify.

20621

14. Race - American Indian. Black, White, etc. White

USA

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12

1 ☐ Never Married 2 ☐ Married

3 X Widowed 4 ☐ Divorced

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker

22. Name and Address of Facility

16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last)

James Walter Lacey

4 □ Donation 5 □ Other (Specify)

18. Mother's Name (First, Middle, Maiden Surname) Minnie Margaret Farrell

19a. Informant's Name/Relationship (Type. Print) George T. Mattingly, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24155 Mattingly-Latham Road Chaptico, MD 20621

20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery

Date April 16. 2009

20c. Location - City or Town, State Bushwood, Maryland

21 Strature of Funeral Service of 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Willo spread Grantitie, Palamany : antrocerched neclostoses

Thomas all lessenones midmental acon

Approximate Interval Between Anset and Death Thonthe

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 24a. Was an

3 Probably 4 Unknown

25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

autopsy performe Yes 2 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home Standard 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1□Yes 2XNo

27. Manner of Death 5 Pending investigation 2 Accident 6 ☐ Could not be

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29a, Certifier

3 Suicide

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and title of certifier Signature

0.1502

April 14, 2009

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

John W. Roache, M.D. 28130 Three Notch Road P.O. Box 186 Mechanicsville, MD 20659

State Registrar 31. Date filed (Month, Day, Year) APR 1 5 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 2002 0505 pr 8009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brook Sand Grave 100151.B 5 mon Hoone Owel 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min 181-30-3638 101 Director January 1, 1908 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 10d. Inside City Limits MD Director Montgomery Sandy Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 18131 Slade School Road 20860 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. □Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White þ Specify Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy rigury or other traumatic event, tre Magnes. Elementary/Secondary (0-12) Health Care College (1-4or 5+) Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guy H. McCoy Edna Dunbar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Bruce McKay 14408 Marine Drive, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State April 7, 2009 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. West, Silver Spring, MD 20901 f Funeral Service Lice 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** your como your /Medical Due to (or as a consequence of): **Examiner** P Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran - a Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Por 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day signed by the a ☐Yes 2MNo 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performs this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ပ 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury After Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation ROLLED OUT OF death. MARCH 30, 2009 3:10 P 1 ☐ Yes 2 X No after death Director: , 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 5AND) within 24 hours aft To the Funeral Di completely filled in BROOKE GIZOVE REHAIS! NURSING CENTER 18131 SLADE SCHOOL PD SPENG 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, R WD D33700 APRIL 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar BTEDHOWE 154 N. ARTICAN ST. WILLHMADET.

Registrar's Signature

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2944 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 14, 2009 Elizabeth Ann Moreland April 6:56 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 28 □ 85 Director 2!7-60-8623 57 April 8, 1952 Maryland Usual Residence of Decedent 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Event her must be notified at once. 10a State 10h County 10d. Inside City Limits Director 1 ☐ Yes & No Maryland St. Mary's Callaway the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45230 Take It Easy Ranch Road 20620 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1√ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 录No Specify: þ If Yes, Give Year or Dates: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Purchasing Agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moreland 01ive Knobel George ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse Moreland, Sr./ Son 49505 Captains Court, Dameron, Maryland 20628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State Charles Memorial 4/20/2009 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hawanced **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transi Due to (or as a consequence of): $E/\iota 29$ bcth / Nore/gndDivision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 100 completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 □₩6 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 10054263

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State Registrar

DHMH 17 Rev 1/2001

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Hassan

Dr Mukhtar H 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Descen A. Janes

25500 Point

ORIGINAL

Leonardtown, Md. 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland	•	artment of He r <i>tificate of De</i>			2000	12945
			Registrar 1. Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death
	Physici /Medic		Janet Isabel Mielke			А	Month pril 5.	Day Year 2009	8:20p M
	Examin	ier	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Lo Frederi	ocation of Death .CK		4c. County of Deal Frederic	h k
١	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last) 96			Hours Min.	Date of Birth (Month, Day, Yea	ar) Co	hplace (State or Foreign untry) nsylvania
	put M		Usual Residence of Decedent 10a, State 10b, County 10c, City,	Town or Loc	cation				10d. Inside City Limits
	Maryia f sho	ō			ballon				1 ☐ Yes 2 🛣 No
	r 28a	Director	Maryland Frederick Monrov	<u>/1a</u>	10f. Zip Code		10g.	Citizen of What Co	untry?
	th with		11793 Cold Brook Drive		21770		USA		
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Specify Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	
35	urs afte	호	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1	I∐Yes 2 X INo 8	Specify:		Specify: Wh	ite
15-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show official Ever, it in the boar cutified at	Completed		16a. Deced	lent's Usual Occupation	on	16b.	Kind of Business/	
7		mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done duri DO NOT use retired)				
7	nt,		17. Father's Name (First, Middle, Last)	Gift S	Store Opera	ator 3. Mother's Name <i>(Fi</i>		seum en Surname)	
land	be side	To Be	Walter Carter Daniels			arah Stewa		•	
ar	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic			19b. Mailin	g Address (Street and				Tip Code)
e, M	s 1 and 3 of Health item 27 other tr		J.C. Mielke Humphries, daughter	11793	Cold Broo				
_	Pages 1 nent of h ant: If ite ary or of		Table Toleriation 3 Linemoval non State		sition (Name of natory or other place)	Date		Location - City or	,
Saitimor	permit, Pages Department of Important: If ii any Injury or once.		Donation 5 □Other (Specify) Fort 21. Sign ture of Emeral Service Licens	Linco	oln Cemete: Name and Address of	ry: 4/10/20	009 Bre	ntwood, l	Maryland Tuneral Home
ă	Dep Imp		Kyan W. Der		401 Ridge				20872
			23a. Part1. Enter the disease, or complications that caused the death. show or heart failure. List only one cause on each line.						Approximate Interval Between
1	Physician		resulting it death)		bation				Onset and Death
	/Medical Examiner		Due to (or as a consequer	nce of):					
		ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	nce of):					
	ecuted and transif	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				-1		
90/00,	e be ex sician a burial-	cal E	Due to (or as a consequent	nce of):					
000	rtificate ng phy as the	fedical	0						
Š	sath cel attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal do	eath 3 🗌	Ectopic pregnancy			23d. Date of del	very Day Year
j	the de	hysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown	ıtn 5⊔	Other (specify)				
ν, Γ	ss that gned t	by PI	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause given i	n Part I.	23e. Did tobacc	o use contribute to	the cause of death?
cords,	require een si oould b					—— II	1 🗆 Yes	2 No 3 Pr	obably 4 💢 Unknown
E E	The law i te has b age 2 sh	Completed					24a. Was an autopsy performed?	prior to o	topsy findings available ompletion of cause of
D.	strifica ctor, p	Be C	25. Was case referred to medical examiner?		26	6. Place of Death (C	1 ☐ Yes 2 💢 I heck only one)	No 1 ∐Yes	2 □ No
5	Physic this o		1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ EF			4 Nursing Home			eify)
5	ding I h. After funer	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	8b. Time of Injury	28c. Injury at Work? M 1 □ Yes	28d. s 2 □No	. Describe how in	jury occurred	
2	Atten or deat ector: by the	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home	e, farm, stre			Location (Street	and Number or Ru	ral Route Number,
5	ital or irs afte ral Dir		4 Homicide building, etc. (Specify)			S	City or Town, Sta	ite)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.	∍dge, death n and/or inv	occurred at the time, restigation, in my opini	date and place, and ion, death occurred a	due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	Vith com	ž	29b. Signature and title of certifier		29c. License nu	umber	29d. [Date signed (Month	
			y, kanga		MDH65835	5		4-6-	2009
-	8		30. Name and address of person who completed cause of death (Item 23 Rohan Rengen, MD, 400 West Sevent			miol- Me		21701	
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e		erick, Mar	yrand .	21701	
	Registra	ar	APR 0 8 2009 Duena S.	. pa	Res				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Sheila Moody 30th 2009 02:10 AM March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallsto Baltmore Randallstown Center WO 8. Date of Birth (Month, Day, Year, May 23, 19 Social Security Number if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 579-94-5031 1 □ M 2 🗓 F 48 1960 D.C. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at D. C. Washington 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 214 37th Place, S. E. 20019 U. S. A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Specify: Black natural", or Baltimore, Maryland 21215-0036 1 Tyes 2√ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Practice Nurse Pages 1 and 2 should be filed vent of Health and Mental Hygis ant; if Item 27 is marked other? Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Johnson Matthew Moody 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 214 37th Place, S. E. Ouentin Crutchfield (Son) Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 □Removal from State Mt. Zion Cemetery 04/07/2009 Baltimore, Md. 5 Other (Specify) 4 □ Denetion Signature of Puneral Service 22 Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washingt Washington, DC 20010 Approximate Interval Between Onset and Death ons that caused the death. \Box not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Pm. Enter the disease, or complic rock, or wart failure. List only or Immediate Cause (Final disease or condition resulting in death) AIDS **Physician** /Medical Due to (or as a consequence of): Examiner Renal Disease End Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 X Natural 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058965 Lumor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D KHAWAJA, M.Y SAIMA 32. Registrar's Signature filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8710c&19b Per FH C890 4/24/09 JH State of Maryland Department of Health and Mental Hygiene All Copies Are Legible. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year BARBARA MATERRE /Medical 2009 07 0920 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Macyland
5. Social Security Number 6. Sex Medical Center BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 56 423-74-2677 Yrs. Director 1952 GEORGIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppartment of Health and Mental Hyglene. Important: I fleam 51 an marked other than "natural", or items 23a or 28a-f show any injurt: If item 75 items when than "natural", or items 23a or 28a-f show any injurt or other traumatic event, its Mardiest Earwise, must be notified as Director Yes 2 □ No MD PRINCE GEORGE'S GLEN DALE Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6405 WOOD POINTE DRIVE 20769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify <u>る</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALFRED MATERRE **BERTHA** MOORE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Glenn Dale JOHN ROLAND HILL/HUSBAND 6405 WOOD POINTE DRIVE GLEN DALE, MARYLAND 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 4/9/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multiple myclom disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Vancomy ein Resista Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con a quence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? Yes 2 🖾 No this certificate Division of Vital 1 ☐ Yes 2 To No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6) MCII mayie, MD Unil. Maryland Med Center 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Roy L. McDowell, Jr. /Medical April 6, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital
5. Social Security Number 6. Sex 7. Age (In yrs Park
If Under 24 Hrs. <u>Takoma</u> Montgomery Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2□ F Months Days Hours 579-84-5843 54 Director Feb 21, 1955 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Mudical Evaninar must be notified as once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's Hyattsville 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4922 LaSalle Road 20782 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: þ Specify Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Construction Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Roy L. McDowell, Sr. Carrie Lovelace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra McDowell - Sister 2524 - 11th Street, NW Washington, DC 20001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Lincoln Mem. Cemetery April 11, 2009 Suitland, MD ature of Funeral Servic , see 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Do not enter the mode of dying, such as cardiac or respiratory arrest, both or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2)(No Completed 1 🗌 Yes 3 Probably 4 Unknown s certificate has birector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 1 ☐Yes 2 ☐ No 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital 1 Yes 2 No Other: 4 Nursing Home ို Unpatient s after dea... ral Director: After ... 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

e Funeral [completely To the within 2

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASREEN KANGO 7701 32. Registrar's Signature State Year) Registrar DHMH 17 Rev 1/2001

29a, Certifier

(Check only one)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

09-030	07
Mary I.	Moulton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lary I. Moulton		S 1- For State Registrar	tate of Maryland		tment of I ficate of L		d Menta		eg. No. 2	009	9 12	91
Physicia Medical Examir		Decedent's Name (First, Midd MARY		JLTON				2. Date of Dea Month April 15, 2	Day Yea		Time of Death 0920 hrs	
		4a. Facility Name (if not institution 17310 Quaker Lane (on, give street and number)			. City, Town, or L Brookeville	Location of D		4c. County of			
Funeral Director		5. Social Security Number 024-24-2409		e (In yrs. last		If Under 1 Year Months Days		Min.	rth(MM/DD/YYYY	9. Birthpl	lace (State or	
any		Usual Residence of Decedent 10a. State 10b. County			own or Location		<u> </u>	JOUNE	, 1723		Od. Inside City L	imits
* .	٦		GOMERY			ANDY SP	RING				X Yes 2	
Maryla	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	nat Country	?	
with the Maryland ns 23a or 28a-f sho be notified at once,	ᇹ	17310 QUAK	CER LA.	Ever in U.S.	13. Was I		860 panic Origin	? (Specify Yes or No		S.A.	n Indian, Black,	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Menial Hygiene, uni. If item 27 is marked other than "natural", or items 23a or 28a-fahrer other traumatic event, the Medical Examiner must be notified at once	Funer		Married Armed Forces?		If Yes	, specify Cuban,	Mexican, P	uerto Rican, etc.)		e, etc.	, meran, black,	
ural",	۵	3 X Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Yaar or Dates:	nnleted) 1		es 2X No Usual Occupation		d of work done	Specify:	WHIT		
5 72 hours al m "natural	ompleted	Elementary/Secondary (0-12)				t of working life.			TOD. KING OF BU	isiness/indt	istry	
215-0036 be filed within 72 ntal Hygiene. *ked other than "ent, the Medical	dwo	17. Father's Name (First, Middle	5+		SOCI	AL WORKI		Name (First, Middle,		SPITA	L	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene, Important: If item 27 is marked other than 'injury or other traumatic event, the Medical	Bec	JOSEPH		OCHRAN	V				PHAGENIA	•	REGG	
D 21 should and Med 7 is man	۱٩	19a. Informant's Name/Relations					and Numbe	er or Rural Route Nur	mber, City or Tow	vn, State, Zi	p Code)	
e, MD t and 2 sho Health and item 27 is		LAWRENCE H. M 20a. Method of Disposition			ice of Disposition	on (Name of cem		TAKOMA P	PARK, MD			
Baltimore, Department of He Department of He Important: or or or or or or or or or or or or or		1 Burial 2 X Crematio 4 Donation 5 Other S	n 3 Removal from Sta	alc	matory or other IBERS C	r place) REMATORY	y 4	-17-2009	RIVERI	DAT.E.	MD.	
Balti bermit. Departm mports njury o	1	21. Signature of Funeral Service	Licensee	7	22. Nar CHAI	ne and Address MBERS FU	of Facility JNERAL	HOME & C	REMATOR	IUM.P	. A .	
Physician	+	23a. Part I. Enter the disease, or	r complication that caused	M0009 the death. D	o not enter the	L CLEVEI mode of dying, s	LAND A such as card	VE., RIVE	RDALE, Nor heat, shock, or heat	art	Approximate Int	
/Medical xaminer	1	failure. List only one cause Immediate Cause (Final disease	a. Asphyxia								Between Onset Death	t and
	1	or condition resulting in death)	Due to (or as a conse		nelium	ras						
	ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse			0						
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68760, certificate be ex nding physician se as the burial	Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ncy				23d. Date of	delivery		
cox 6876 eath certificate attending phy for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?	I Live Ditti	time of death		death 3 _ r (Specify)	Ectopic pr	regnancy	Month	Day	Year	г
Box he death c y the atten hed for us	ᇍ		known g Unknown					[00 B:11				
P.C es that igned be deta	≥	Part II. Other significant condi	tions contributing to death	n but not resu	uiting in the und	lerlying cause gr	ven in Part I		obacco use contr s 2 ✔ No 3			
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Recol The law cate has	Completed		-	-				perfo	rmed?	death?	2 N	
of Vital Records, ig Physician: The law requir wher this certificate has been s meral director, page 2 should the	ង្គ	25. Was case referred to medica examiner?	Hoonital		D/O testiont		Other:	neck only one)	Basitana	4 011 0		-
of V ing Phys After thi	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y	iry 2	R/Outpatient 3 8b. Time of Inju	30,,	y at Work?		Residence 6 how injury occurr	red		
Sion ttendii death ctor: A	atio	1 Natural 5 Pend 2 Accident Inve			d 9:15	am 1 Ye	es 2X N	helium	purpose gas	efully	y inhal	ed
Division of Vital Pospital or Attending Physician: hours after death uneral Director: After this certifi y filled in by the funeral director,	Certification;		d not be		e, farm, street, at home	factory, office bu	uilding, etc.		Street and Number State) 1731(okeville			
To the Hospital within 24 hours To the Funeral completely filled	<u> </u>	29a. Certifier 1 Certifying P	hysician: To the best of my	y knowledge,	death occurred			, and due to the caus	se(s) and manner	r as stated.		
F P S	E -	29b. Signature and title of certific	and manner stated, er			29c. License	number		29d. Date sign	ed (Month,	Day, Year)	
		Dun) L m			0.C.N	И.Е. ————		April 16, 20)09		
		 Name and address of person Donna M. Vincenti, M 	· ·		*	enn Street,	Baltimore	e, MD 21201			Min =	50002
Sta	-	31. Date filed (Month, Day, Year)	3 Pegistran	r's Signature	1.5	7)						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1.5 **Physician** Year 09 04 1542 Henry Hugh McKenzie, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**X** M 2□ F 09-27-1942 Director 66 213-44-2046 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Evantine court to rother any injury or other traumatic event, the Modeal Evantine court to be notified at any injury or other traumatic event. 10d. Inside City Limits Director 1 ☐ Yes 2 No Frostburg MD Allegany 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 200009 National Hwy NW 21532 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry H. McKenzie, Sr. Evelyn Stott McKenzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie McKenzie wife 200009 National Hwy NW Frostburg, MS 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 04-18-2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Sowers Funeral Home, 111 Sowers ma0547 Hon Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** my acute disease or condition resulting in death) 00 /Medical Due to (or as a consequence of) Examiner ofon or Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) burial-transit Exami and Due to (or as a consequence of): physician at the burial P.O. Box 68760 The law requires that the death certificate be Physician/Medical signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □ Yes 1 ☐ Yes 2 ☐ No 2 Mo 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending P n 24 hours after death. e Funeral Director: After t eletely filled in by the funera 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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APR 2 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01

31. Date filed (Month, Day,



021244

umberland, MD

09-02881	
Raymond Melzer	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ymond Melze		State of Maryland / Department of Health a 1- For State Certificate of Death	and Mental Hygiene 2009 1295
Physicia	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day April 10, 2009 3. Time of Death 1705 hrs
edical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town	n, or Location of Death 4c. County of Death
Funeral		Rt 70E at 10 mile marker Hancock 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months I	Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		Usual Residence of Decedent	14-29-1933 Country) PA
i. e.		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No
Maryland r 28a-f sh ed at onc	Director	10e, Street and Number 10f. Zip Coo	de 10g. Citizen of What Country?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other travmatic event, the Medical Examiner must be notified at once.	Funeral Di		of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	Andrew S Melzer	18. Mother's Name (First, Middle, Maiden Surname)
e, MD 21 I and 2 should Health and Me item 27 is ma	ပ္	Trudy Melzer 3701 Brinu	Street and Number or Rural Route Number, City or Town, State, Zip Code) Val Dr. West Mrfflin PA 15122 of cemetery. Date 20c/Location - City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If itei		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	Bark 4-14-09 Pittsburg PA
Balti permit. Departn Import injury		Chat Condustry Blassouth	Green Street Berkeley Springs, WV254111
Physician 'Medical aminer		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of defailure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	tying, such as cardiac or respiratory arrest, shock or fleart poroximate Interval Between Onset and Death
tammer		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
d sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
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x 68760 h certificate the cert	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify	3 Ectopic pregnancy 23d. Date of delivery Month Day Year
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Records, F. The law requires ficate has been sign.	Completed		24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 Yes 2 ✓ No 1 Yes 2 No
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Division tal or Attendia rs after death.	ertification:	1 V Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, c	
Divisior To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	၂ပ	O 29a Certifier	ime, date and place, and due to the cause(s) and manner as stated.
To the Hos within 24 h To the Fu	Medical		License number 29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	
	State	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Base 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	
Regi		ADD O COOOL D	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me, g891,05 Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert **Physician** Α. Milburn APPI1 11^{pay} 2009^{ear} 10:05 RM /Medical 4a. Facility Name (If not institution, give street and number)
Cumberland Memorial Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□F 79 234 46 7945 Director April 18,1929 Morgan Co.,WV Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Examiner must be notified at WV Morgan Great Cacapon 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 25422 3132 Doe Gully Lane U.S.A. items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: White 1 ☐ Yes 2X No Specify: ò 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than "I rent, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 9 Farmer Farming Pages 1 and 2 should be filed and the filed and Mental Hyginnert of Health and Mental Hyginnt: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marvin Newton Milburn Edna Pauline Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25411 item 27 other tra William Milburn-Nephew 352 Theodore Hawvermale Rd., Berkeley Springs, W 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oti 1 Burial 2 Cremation 3 ☐Removal from State Hagerstown Crematory 4/17/09 |Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 24121212720hison Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 95 Union St., Berkeley Springs, WV 25411 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NEUKO /Medical Due to (or as a consequence of) Examiner CENTRALION MORPOVED BY IN ONM Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed bunal-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached Division or Vital Records, P.O. 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been siç , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No certificate 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred
Subject operating Tractor when
it overturned and fell on him 28b. Time of 28c. Injury at Work? After Medical Certification: Hospital or Attending Injury Natural 5 Pending 1X Yes 2 □ No 2X Accident 03/23/2009 5:00 p. ^M within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number City or Town, State) 132 Doc Gully Lane 4 Homicide Field Great Capacon, West Virginia Centryipe Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Centryipe Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 00

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

HRN

32. Regis rar's Signature

30. Name and address of berson who completed cause of death (Hem 23a) (Type, Print)

filed (Month, Day,

Year)

OAPR

23167

902 Seton Drive, Cumberland, MD

5+1 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month APRIL **Physician JACK** Day EUGENE MOBERLY 14,2009 7:18A /Medical 4a. Facility Name (If not institution, give street and number)
FREDERICK MEMORIAL HOSPITAL c. County of Death FREDERICK Examiner 4b. City, Town, or Location of Death FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/23/1937 Birthplace (State or Foreign Country) **Funeral** 6 Sex 7. Age (In yrs. last birthday) Days Hours 1**⊠** M 2□ F Director 214-36-2179 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Wedton Ever in wearthan and on the traumatic event, the Wedton Ever in wearthan and on the file of the medical Ever in wearthan and the management of the weather the Wedton Ever in wearthand and the Maryland and 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Thomas Avenue 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates: 1960-64 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 21∏ No þ Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) manager gun center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Robert Moberly, Jr. Grace Viola Wisner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Moberly / son 10033 Pine Tree Rd., Woodsboro, MD 21798 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department o Important: If i any Injury or once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 4/18/2009 |Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home Jayuche Kneh MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cute 1 Day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, r pertension 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1∐Yes 2 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2XINo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes After this မှ 1 Inpatient ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred Natural 2 Naccident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 516 43 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

DIL DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

22

ORIGINAL

32. Pégistrar

Dr. Hiren Shah

Registrar

State

Hospital

Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Green

31. Date filed (Month, Day, Year)

3001

32. Registrar's Signatur

APRIL 13, 2009

Dr., Cheverly, MD. 20185

	Registrar				Ce	rtificate of	Death		Reg. No. 2	nno	1205
ın	Decedent's Name (2. Date of Do	Day	2009 2009	3. Time of Death
al	MICH		WILLIA		UTT	41. O't. T	- l ti of Dook	April			8:55 P M
r	4a. Facility Name (If no 10 Wynfal			mber)			or Location of Deat isfield	n		nty of Death Nerset	
	5. Social Security Num		Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi		9. Birth	hplace (State or Foreign
	213-46-88	809	1⊠M 2□F	62	Yrs.	Months Days	Hours Min.	Sept. 1	6, 1946	Ma	ryland
ŀ	Usual Residence of De	ecedent 0b. County		10c Cit	ty, Town or Lo	ecation					10d. Inside City Limits
	Maryland	Somer	set	100. 010		isfield				İ	1 XYes 2 No
L	10e. Street and Number	er	-			10f. Zip Code			10g. Citizen o	of What Cou	
	10 Wynfall	. Avenue	<u> </u>				1817			S.A.	,
	11. Marital Status		12. Was Dece	edent Ever in U.	.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or N	o- 14. R	Race - Amer	
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ľ	17. Father's Name (Fit		it)				18. Mother's Nar		e, Maiden Surn	ame)	
	Dorsey Off	utt					Mary Je	an Ott			
ſ	19a. Informant's Name	· ·			1	-	and Number or Ru		-		
_	Karen Offu		vite)			<u> </u>	venue - C			21817	
	20a. Method of Dispos 1 ☐ Burial 2 🔯 0		☐Removal from	State I		sition (Name of natory or other place		Date	20c. Locatio	-	
-	4□Donation 5	☐Other (Spec	ify)	Sa]		Cremato		/09 ———	Salisb	ury,	MD
	21. Signature of time	6479	30,1	//	< B	2. Name and Addre radshaw	& Sons Fu	neral H	Iome		_
	Rober 23a. Part 1. Enter the		adshaw,				in St			218]	Approximate
	shock, or heart f Immediate Cause (Fir	failure. List only	y one cause on e	ach line.	iii. Bo plot oili	or the mode or dyn	ng, scon as cardia	e espiratory t	arrest,		Interval Between Onset and Death
	disease or condition				0	0 1					Office and Death
	resulting in death)		a. Due to	or as a consequ	25/3 uence of):	of th	e Li	ver			
	resulting in death)	1	a. Due to	(or as a consequ	uence of):	of th	e Li	ver			
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DHMH 17 Rev 1/2001

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muel T. Poole,	1-	State of Maryland / Department of For State Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate	of Health and Mental Hy of Death	ygiene Reg. No	. 20	00 120				
Physician	n/	Decedent's Name (First, Middle,Last)		Date of Death Month Day	to do To	3. Time of Death				
edical Examin	er	Samuel Theodore Poole, Jr.	U. O'. Town and position of Dogth	April 14, 2009	c. County of Death	0839 hrs				
	4	a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick		Frederick					
Funeral Director	- 1	Social Security Number 6. Sex 7. Age (In yrs. last birthday) $214-46-5877$ $1\times M$ 2 F 62 Y	If Under 1 Year If Under 24Hrs Months Days Hours Min.		947 Ma	ountry) cryland				
	L	sual Residence of Decedent				10d. Inside City Limits				
w any	- [Oa. State 10b. County 10c. City, Town or Loc				1 Yes 2 X No				
yland n-f sho	핡	irginia Berkely Falling Oe. Street and Number	Waters 10f. Zip Code		itizen of What Cou					
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	9665 Williamsport Pike	25419		ited St					
th with	era		Was Decedent of Hispanic Orlgin? (Sp f Yes, specify Cuban, Mexican, Puerto		White, etc.	rican Indian, Black,				
er dea		1XX Yes 2 No	Yes 2 X No specify:		Specify.Whi	te				
urs aft tural	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	tent's Usual Occupation (Give kind of		. Kind of Business	/Industry				
72 hor "na sal Ex.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use reti $chinist$		rinting	Ţ				
vithin ene.	d m	12		e (First, Middle, Maid						
Hygi		7. Father's Name (First, Middle, Last) Samuel Theodore Poole, Sr.		Elaine I						
212'	e Be	9a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or	Rural Route Number,	City or Town, Stat	te, Zip Code)				
2 shour and 1	-1	andra Poole/ Sister 631	13 Ford Road, F	rederic	c, MD 2	1702				
e, N 1 and Health item	F	20a. Method of Disposition 20b. Place of Disposition	position (Name of cemetery, other place)	ril 17.1	c. Location - City o					
nor Pages ent of nt: If	- 1	1 X Burial 2 Cremation 3 Removal from State Res 1 4 Donation 5 Other Speqify: Memori	chaven Lal Gardens 2	2009 1	Frederi	ck, Maryland				
altir mit. F partme portai	1		2 Name and Address of Facility Resthaven Funer 9501 Catoctin Mt	ral Servi	ices, Si	kkot CodyPA				
M For I			3501 Catoctin Mt	tn. Hwy.	Frederi	Ck, MD 21701 Approximate Interval				
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y, P.O. Box 6876C ires that the death certificate signed by the attending physical by detached for use as the b	Physician/Me	1 Yes 2 No 9 Unknown g Unknown								
O hat the sd by the etache		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.			to the cause of death?				
ires the signe	d by			1 Yes		autopsy findings available				
ords,	olete			24a. Was an autopsy performe	prior t	o completion of cause of				
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n of Vital Records, ling Physician: The law requir After this certificate has been si funeral director, page 2 should I	e e	25. Was case referred to medical examiner?	26.Place of Death (Chec							
Vit hysica this c	To B	1 V Yes 2 No Inpatient 2 V ER/Outpat	acite o Box	sing Home 5 Re		her:				
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ivision or Attend after death Director:	atic	2 Accident Investigation 28e. Place of Injury - At home, farm,		28f Location (Stre	et and Number or	Rural Route Number, City				
Division pital or Attendin ours after death neral Director: A	Certification:	Suicide Could not be determined (Specify)	outout, ractory, onice building, etc.	or Town, Stat		,,				
Hospital 24 hours Funeral tely fille		29a. Certifier 4 Continue Physician: To the best of my knowledge death of	occurred at the time, date and place, a	nd due to the cause(s	s) and manner as s	tated.				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Examiner: On the basis of examination and/or inves	stigation, in my opinion, death occurred	d at the time, date an	d place, and due to	the cause(s)				
To wit	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)				
		pull 8 m	O.C.M.E.	,	April 15, 2009					
+1		1.0000	111 Penn Street, Baltimore,	MD 21201						
St Regist	tate trar	31. Date filed (Month, Day Year) 32. Registrar's Signature	ake							
HMH 17 Rev 1/20	2001	ORIG	INAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28 Day **Physician** 09 Year Hilda Joyce Poore 3:00a M /Medical 4a. Facility Name (If not institution, give street and number) William Hill Manor 4b. City, Town, or Location of Death Easton 4c. County of Death Talbot Examiner Social Security Number 213-26-6438 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 12-14-1927 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Min. Months Days Hours Cordova, Md Director Usual Residence of Decedent the Maryland 3a or 28a-f show t be notified at 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Talbot Md Bozman Director 1 Yes 2 No 10e. Street and Number 8023 Bozman Neavitt Rd. 10f. Zip Code 21612 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Experiment unat by 100ce. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Ad Clerk Planner Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Clifton Cole Hilda Catherine Callahan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9101 Bozman Neavitt Rd. St. Michaels, Md. 216 Marsha Kastel (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bozman Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Xurial 2 ☐ Cremation 3 ☐ Removal from State 3-31-09 Bozman, Md. 4 ☐ Donation 5 ☐ Other (Specify) R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 21663 21. Signature of Funeral Service Licenses Shotise 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular **Physician** Leas /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. e Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2

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State Registrar 31. Date filed (Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

nword & Faston ms 2160)

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State Registrar

DANIELLE DOBERMAN, MO 6565 NCHARLES ST. SUITE 209 BALTIMORE, MO 21204 31. Date filed (Month, Day, Year) APR 07

29b. Signature and title of certific

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D64395

29d. Date signed (Month, Day, Year)

MARCH 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year PATRICIA POPPF /Medical <u>ANN</u> 200 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death REGIONAL HICOMICO en INSUM 39615 bill Social Security Number 6. Sex If Under 1 Year | If Under 24 Ars. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** . Date of Birth (Month, Day, Year) Days 1 ☐ M 2 💢 F 148-42-2570 Director 57 05/02/1951 NEW JERSEY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is indicated any injury or other traumatic event, it is indicated any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No VIRGINIA **ACCOMACK** PARKSLEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18418 JOHNSONS LANDING ROAD 23421 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🎇 No Specify. ₽ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +3 DISPATCHER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN EDWARD POPPE ၉ LORENA MATTHEWS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN EDWARD POPPE / FATHER 18418 JOHNSONS LANDING ROAD, PARKSLEY, VIRGINIA 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) PLEASANT GROVE UMC CEMETERY. 04/07/2009 JACKSON, NEW JERSEY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 25046 PARKSLEY RD., PARKSLEY, VA 23421 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** who disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hepstiti Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the ceath certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) P.0 signed by the a 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Division of Vital 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death After 1 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

APR 0 6 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0335AM Frances Marie Quade 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F Months Days Hours Min. 215-36-3218 83 October 7, 1925 <u>Maryland</u> Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22810 Dorsey St. Apt. 202 20650 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify Specify. 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Thompson Teresa Mary Greenfelder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Leonard Quade, Jr. Son 27280 Four Log Lane Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State April17,2009_{Alexandria}, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service I 22. Name and Address of Facility Mattingley-Gardiner Funeral Home. P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se disease or condition resulting in death) Due to (or as a con equence of) Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Tyes 24 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of

Physician /Medical Examiner

Department of Health an Important: If item 27 is any injury or other trauonce.

Physician

/Medical

Examiner

Funeral

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Director

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th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, Inc. Wedical Exament on the northy of

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-tran After this certificate has page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, al or Attend after death Director:

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by Be Certification:

28a. Date of Injury (Month, Day, Year)

28d. Describe how injury occurred

1 Matural 5 Pending investigation 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28c. Injury at Work? 1 Tyes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie

D0067399

29d. Date signgd (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St.

Theodora Fynn, MD 31. Date filed (Month, Day, Year)

Mary's Hospital 25500 Point Lookout Rd. Leonardtown, MD 20650 Registrar's Signature



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2009 14:10 MARCH VERONICA ROMALDA RAMSEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE SAINT AGNES 9. Birthplace (State or Foreign Country) Trinadad-5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 7, 1933 Months Hours Days 1 M X F 76 212-68-3151 Tobago Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Rockville Yes 2 ☐ No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 321 Mt. Vernon Place U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2√∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 4 vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Joseph Charles Fraser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 321 Mt. Vernon Place, Rockville, MD 20850 Fred Ramsey (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Buria 2 Cremation 3 Removal from State 4/8/09 4 □ Donation 5 □ Other (Specify) Parklawn Mem Park Rockville, MD 21. Signa Te of Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): UNKNOWN HEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🔭 No 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ✔ ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE DIABETES TYPEIT 24a. Was an autopsy performe DEEP VIEW THROMBOSIS 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

Completed by

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If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Medical Exercities or ust be notified at

Pages 1 and 2 should be filed within 72 hours after

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Important: If it
any injury or c

Baltimore, Maryland 21215-0036

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/Medical

2

Be Completed

Certification: To

Medical

State

Registrar

3 Suicide

29a, Certifier

4 Homicide

Division of Vital Records, P.O. Box 68760,

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Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part
ILVOSOTENE INN	CEREDOM MARINING ACIDENT

SEIZURE DISORDER 25. Was case referred to medical examiner?

> 28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

08

MEDICAL DOCTOR

20661

CATON AUE, BALTIMORE, MD

MARCTI 30 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MokuRI

SAMUEL 31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hours a

To the Funeral C

completely filled

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death A Month 3rd Day ZDOG Robert Reeves Reid 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Glen Baltimore Washington Medical Center Ishini 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Min. Days Hours 180-16-2573 Pennsylvania July 19,1921 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 251 Tolstoy Lane 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No WW] If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married WWII 1 ☐Yes 2 No Specify White Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ARRADCOM** Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Jackson Reid Helen Gertrude Reeves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas E. Reid / Son 251 Tolstoy Lane Severna Park, MD 21146 20b. Place of Disposition (Name of April 07, 20a, Method of Disposition 20c. Location - City or Town, State Atlantic Crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) LLC Signature of superal Se Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 701 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐Yes 2 NO 1 ☐ Yes

Physician /Medical Examiner

the attending physician

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Physician

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28a-f show

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the field and executed to notified an

72 hours after

2 should be filed within h and Mental Hygiene.

of Health

permit. Pages 1 and Department of Healt Important: if item 2: any injury or other 1

other t

Baltimore, Maryland 21215-0036

Examine use as the burial-trans Physician/Medical signed by the a ۾ Completed Be

27. Manner of Death

25. Was case referred to medical examiner?

1 Yes ≥ No

1-Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified

page 2 s certificate funeral director, After this Certification: To death. Director: filled in by the hours after

Hospital or Attending Physician: within 24 hours a

To the Funeral C

completely filled Medical To the I-within 24 State

Registrar

and manner stated

Date of Injury (Month, Day,

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 \sum Nursing Home

1 ☐Yes 2 ☐No

26. Place of Death (Check only one,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day,

5 ☐ Pending investigation

6 ☐ Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend	#18	T- State Registrar FH. TCHD. 04		ryland / Dep			lealth a Death	and Me		jiene eg. No.	2000	1296
Physic /Med		1. Decedent's Name (First, Middle, La Norman McQua	st)						2. Date of Dea 3 ^{Month}	th 29 ^{Day}	2009	3. Time of Death 2:00a M
Exami		4a. Facility Name (If not institution, given 8763 Dawson	Road		St	. Mi	Location o	els			County of Death Talbot	
Funeral Director		5. Social Security Number 6. S 1 9 4 – 1 8 – 4 1 8 5 1 Usual Residence of Decedent		(In yrs. last birthday 83 Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 3 – 8 – 1	926	9. Birth T 1 1	place (State or Foreign ntm) gnman, Md
B Marylend a-f ehow	ctor	10a. State 10b. County Md Talbot		10c. City, Town or L St. Mic		.s						10d. Inside City Limits Yes 2 □ No
th with the 23a or 28	Funeral Director	10e. Street and Number 8763 Dawson	Road		10f. Z	ip Code 2166	3		1	0g. Citi: US	zen of What Cou	intry?
be filed within 72 hours efter death with the Marylend ital Hygiene. Indicate then "natural", or items 23a or 28a-1 show event, the Modical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Acroed Forces? 1 19 Yes 2 No Sive Year or Dates:	If Yes, specify Cuban, Mexican, Puerto				gin? (Spec , Puerto F	pecify Yes or No- Dican, etc.) 14. Race - American India Black, White, etc. Specify: White			, etc.
id 2 should be filed within 72 hours eff than and Mental Hygiene. 27 is marked other then "natural", or treumatic event, the Medical Exam.	Completed	15. Decedent's E. (Specify only highest gra	de completed) College (1-4or 5-	(Giv	edent's Us e kind of w DO NOT ne Ma	ork done d use retired	during most I) ts			Gr	nd of Business/Ir	ndustry
should be filed ind Mental Hygi I marked other umatic event,	To Be	17. Father's Name (First, Middle, Last) George Camp	_				Nan	MæQ	(First, Middle, Luay	MC	Quay	
		19a Informant's Name/Relationship (Virginia Lee					Road				Town, State, Zi LS, Md 2	
of to		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	()	20b. Place of Disp cometery, cre Capito	matory or L Cr	other place emat	ory 4	4-1-	2009	7od	cation - City or T Ver De	
permit. Peg Department important: if eny injury o		21. Signature of Funeral Service Licer	Hely								Home,	PC 21663
Physician /Medical Examiner	ľ	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ARTE	the death. Do not ere. 405CLEVLO a consequence of):							ISE	Approximate Interval Between Onset and Death
4	dical Examiner	Sequentially list carditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):								5.020
The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use es the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 Fetel death 3	□Ectopic □ Other (s					2	23d. Date of deliv Month	rery Day Year
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Physician: this certific ral director,	9 Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:					26. Place of Death (Check only one)				
	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?			4 11401	2	ome 5 M Residence 6 □Other (Specify) 28d. Describe how injury occurred		<i>fy)</i>		
el or Attending s after death. ii Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of Inju	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			2	281. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifying Ph (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	examination and/or i	th occurred nvestigation	d at the tim	ne, date and pinion, deat	d place, at	nd due to the cod at the time, d	ause(s) ate and	and manner as place, and due to	stated. to the cause(s)
To the To the comptet	×	29b. Signature and title of certifier	Atterens	, ay	29	Oc. License	5796	8	2		e signed (Month,	
GHVA		30. Name and address of person who Robert J.							St. M	iich	aels,M	d.21663
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	hak							

DHMH 17 Rev 1/2001

			1 - State Registrar	<u> </u>	Cei	tificate of			Reg. No. 2	009	1296								
	Physici /Medic		1. Decedent's Name (First, Middle, Last) LOIS ANNA RONEY					2. Date of D Month Apri	Day	Year 2009	3. Time of Death 7:00 PM ^M								
	Examir Funeral Director		4a. Facility Name (If not institution, give Genesis Health 5. Social Security Number 6. Sec 578–18–4621	Care - C	The Pines (In yrs. last birthday) 88 Yrs.		Hours Min.	h 8. Date of B	4c. Count	y of Death [albo	t ace (State or Foreig ry)								
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is merked other than "natural", or items 23a or 28a-f show other traumetic event, the Marical Examination and other traumetic event, the Marical Examination at	'n	Usual Residence of Decedent 10a. State 10b. County MD TALBOT		10c. City, Town or Loc	cation		2,011 22	., 1,20		d. Inside City Limits								
		Direct	10e. Street and Number		DASTON	10f. Zip Code			10g. Citizen of	What Count									
5-0036		sted by Funeral Director	1 Never Married 2 Married ★★Widowed 4 Divorced 15. Decedent's Edu	12. Was Decedent E Armed Forces? 1 Yes XXN If Yes, Give Year or Dates:	0 1 16a. Decec	☐Yes XXNo	Hispanic Origin? (S an, Mexican, Puerl Specify:		USA 14. Ra Bla Speci	MITT	E.								
2121		Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5-	-) life. L	IKMAKER			OWN HO										
⊑ .	2 should be fill and Mental F Is merked otl aumetic ever	To Be	17. Father's Name (First, Middle, Last) ANDREW L. SODEMAN 19a. Informant's Name/Relationship (Ty	na Print)	10h Mailin	a Address (Street	18. Mother's Nar	AMES	le, Maiden Surna										
more,	permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is i eny Injury or other traui once.		RONALD RONKY-SON 20a. Method of Disposition 1 X Xurial 2 Cremation 3	emoval from State	20b. Place of Disposemetery, crem ST. JOSEPH	OLD SKT sition (Name of natory or other place I; S CEME Name and Addre	PTON RD. Ce) TERY 4-1 ess of Facility	CORDOV Date 3-2009	ZOC. Location	625 - City or Tow	vn, State								
P	The law requires that the death certificate be executed The last been signed by the attending physician and labeled for use as the burial-transit	Examiner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or limmediate Cause (Final disease or condition resulting in death) 5 agust tighty list continue, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	cations that caused le cause on each line Due to (or as a Due to (or as a	the death. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate interval Between Onset and Death								
P.O. Box 68760,		ification: To Be Completed by Physician/Medical	Physician/	Physician/	Physician/	Physician/	Physician/	Physician/	Physician/	Physician/	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome c 1	Petal death 3 time of death 5	Ectopic pregnanc Other (specify)		23a Did	М	
ords,	s been signers should be a		The state of the s								bly 4 Mhknown								
Vita	IIng Physician: 1. After this certifica funeral director, p		25. Was case referred to medical examiner? 1 ☐ Yes 2 ₩ 0 H	ospital:	nt 2 ☐ ER/Outpatien	Oth	26. Place of Dea	peri 1 □Yes ath <i>(Check</i> o <i>nly</i>	opsy formed? 2 No	prior to com death? 1 ☐ Yes 2									
vision			-	Certification: To	27. Manner of Death Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day)	y Year) 28b. Time of Injury	28c. Injur Worl	y at	28d. Describe	how injury occur	red							
jo			29a. Certifier (Check only 2 ☐ Medical Examir	sician: To the best of ner: On the basis of	f my knowledge, death examination and/or inv	occurred at the tilestigation, in my o	me, date and place	and due to th	own, State) e cause(s) and me, date and place.	nanner as sta	ated.								
To the		Medical	29b. Signature and title of certifier	and manner stat	ed.	29c. Licens	e number	- 30 070 01710	29d. Date signe										
	TLS 2		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type, F		33336 NS LAN	ik L	HARIL -ASTO	- 06 J. MD	21601								

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) APR 0 7 2009

Lois Roney

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 – For Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H		, ,	iene 	9 12965
	Physici /Medio		Decedent's Name (First, Middle, Last Donna Jean Riggin	•				2. Date of Deat Month 04	Day	Year 3. Time of Death
	Examir		4a. Facility Name (If not institution, give 239 Fairview Stre	et		4b. City, Town, or Luke			4c. County of	f Death Legany
	Funeral Director		5. Social Security Number 6. Se 232-84-0794	X 7. Age	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 7,		9. Birthplece (State or Foreign Country) Michigan
the Marylend	the Marylend 28a-1 show	Director	10a. State 10b. County MD Alleg 10e. Street and Number		10c. City, Town or Lo		_	11	0g. Citizen of W	10d. Inside City Limits X Yes 2 No
036	ould be filed within 72 hours efter death with the Marylend Mental Hygiene. arked other than "natural", or items 23a or 28a-1 show attc event, the Madical Exeminar must be notilised at	by Funeral	239 Fairview S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 (ANO If Yes, Give Year or Dates:			L 540 spanic Origin? (S n, Mexican, Puert Specify:		Unit	ed States - American Indian, , White, etc. White
Maryland 21215-0036	itled within 72 ho Hygiene. ther than "natur nt, Ire Madical.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12		(Give life. l	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor	king ne (First, Middle, M	Restau	rant
ryiand	should be filed nd Mental Hygi markad other umatic event, I	To Be	Walter Stevens 19a. Informant's Name/Relationship (7)		10h Mailie		Cath	erine (Ca	11ihan)	Stevens
a o	permit. Pages 1 and 2 should b Department of Health and Menit important: if item 27 is marked any injury or other traumatic e <u>once.</u>		Brandon Wicken 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	nofer	200. 20b. Place of Dispo	ng Address (Street a Second Research Sition (Name of natory or other place and Cremat	Dr. Xei	nia, OH 4	5385	City or Town, State
Balt	permit. Departmine imports any inju		21. Signature of Funeral Service Licents	Sutt		Name and Address		e, 85 S.	Main St	reet Keyser, WV
,8/60,	death certificate be executed By Again By Ag	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ASCVD Due to (or as a Due to (or as a Due to (or as a c.	consequence of):	er the mode of dying	, such as cardiad	c or respiratory arre	ist,	Approximate 726 Interval Between Onset and Death
O. Box 6	the death certific by the attending pached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
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IVISION OT or Attending Physical death. Irector: After this or by the funeral did	or Attending Physics death. Itsector: After this by the funeral di	Certification: To Be	examiner?	No						
	To the Hospital of within 24 hours af To the Funerel Completely filled in	ledical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and man ite and place, ar	ner as stated. Indidue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier 30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type	29c. License D 0 9 1 !	57	A	pril 1	(Month, Day, Year) 4 2009
	Sta Registr		Paul Sno 31. Date filed (Month, Day, Year)	DW M D 32. Registrar	Dpty Med	Ex 123	W 3rd	St Cumb	erland	MD 21502

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Charles L. Riden, Sr. 09 04 13 2208 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY Birthplace (State or Foreign Country)
 WV If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12/08/1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1√2 M 2□ F 236-62-0106 74 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show 1,□Yes 2□No Director WV Mineral Keyser 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1425 Lynmar Street 26726 United States Funeral 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ If S 2 ☐ No

If Yes, Give
Ye ar or Dates: 1952-1974 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married is marked other than "natural", or 1 □Yes 2 No Specify. White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Foreman Power Plant 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othrany Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles A. Riden Beulah I. (Sine) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy S. Riden (wife) 1425 Lynmar Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Potomac Memorial Gardens 04/17/2009 Keyser, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wet Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 26726 Onset and Death Immediate Cause (Final disease or condition resulting in death) MESOTHELIOM Physician /Medical Due to (or as a consequence of): Examiner ORONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CHRONIC OBSTRUCTIVE and Due to (or as a consequence of): physician certificate be Physician/Medical the attending IF FEMALE: nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 Month Year Day Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No the detached 9 Unknown q | Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☑ No 2 PNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Inpatient 2 ER/Outpatient 3 DOA ဥ Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide

Box 68760, o 9. of Vital Records, Hospital or Attending Physician: completely filled in by the funeral Division within 24 hours after death To the Funeral Director:

3altimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and the of certifier

Ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 02 Seton 31. Date filed (Month, Day, Year) APR 2 2 2009

ve Suite 32. Registrar's Sig

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00066691

29d. Date signed (Month, Day, Year)

2150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep 1 - State Registrar Ce	partment of Health and I Pertificate of Death	Mental Hygier	2000 12067
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medic		Barbara B. Saunders			05 2009 8:35 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
			Holy Cross Hospital	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		578-50-9687 70 To 100 T		11/13/193	NC NC
	land ow		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	Mary -f sh	ţo	MD Prince George's Hyattsv	i11e		1⊠Yes 2□No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a o	a D	6605 24th Avenue	20782	US	SA
	death	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian, Black, White, etc.
9	or ite		Armed Forces? 1 □ Never Married 2 □ Married I □ Yes 2 ☒ No If Yes, Give	1 □Yes 2 No Specify:	o Hoan, cto.,	Specify:
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Evertiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			Black
7	"natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of wor . DO NOT use retired)	king 16b	. Kind of Business/Industry
12	within sne.	Ę	Elementary/Secondary (0-12) College (1-4or 5+)	al Service Supervi		ederal Government
d 2	filed within Hygiene. other than '		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
an	should be filed within and Mental Hygiene. marked other than imatic event, the M	To Be	Ernest Bowden Sr.	Pearl S	mith	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventher must be notified at	Ĕ		iling Address (Street and Number or Ru		ty or Town, State, Zip Code)
	1 and 2: Health a em 27 is		Leesha A. Saunders/Daughter 5106	North Capitol St.	NW Washin	gton DC 20011
Baltimore,			20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)		. Location - City or Town, State
E	permit. Pages Department of Important: If its any injury or o		1 Ma Burial 2 Li Cremation 3 Li Removal from State		1 10,20¢9 _{.a}	ndover, MD
alti	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee Par	Name and Address of Facility Ma		
m	Dep Imp			4217 9th St NW Was		
			23a. Part 1 Enter the disease, or complications that caused the death. Do not e show, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
1	Physician	i i	Immediate Cause (Final disease or condition Hypoxia			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner	_	Sequentially list conditions. Pneumonia			
_	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate calls. Each of the right cause (Disease or injury) Cause (Disease or injury) The use			
)	and and I-tran	xar	Cause (Disease or injury that initiated events resulting in death) Last C. Ileus Due to (or as a consequence of):			
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387	phys phys s the	edical	d			
×	eath certific attending p for use as t	NE NE	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	Jeath atter	Physician/M	in the past 12 months?	B ☐ Ectopic pregnancy □ Other (specify)		Month Day Year
0	at the de by the tached	hysi	9 Unknown			
ď.	ned t	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Ę	quires en sign uld be	b d			1 ☐ Yes	2 No 3 Probably 4 Unknown
ပ္တ	aw requir s been s s should	olet			24a. Was an	24b. Were autopsy findings available
æ	The law	Completed		-	autopsy performed 1 □ Yes 2 🖎	prior to completion of cause of death? No 1 □ Yes 2 ♣ No
Vital Records,	sician: Th certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	10 100 2010
Į (is is	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	e 6 ☐ Other (Specify)
n of	ding Ph J. After th funeral	Ľ:	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury Injury		28d. Describe how in	njury occurred
Division	or Attending ifter death. Director: After in by the fune	Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Ξ	i or Attenc after death Director: d in by the	ij	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, suitiding, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	ral D					
	o the Hospital or after thin 24 hours after the Funeral Direction of the Funeral Direction of the funeral tilled in the funeral filled Medical	29a. Certifier (Check only one) 2□ Medical Examiner: On the basis of examination and/or and manner stated.				
	To the Hosp within 24 ho To the Fune completely f	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			VIEW			
	Q		30. Name and address of person who completed cause of death (Item 23a) (Typ	D19563	4/	6/09
			Purniona Joshi 1500 Forest Glen Road		20910	
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
	Regist		APR 08 2009 Perus B. A	ales.		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5, 2009 7:30 AM APRIL CHARLES PRESTON THOMPSON, SR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY North Potomac 12622 Fellowship Way | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year May 12, 15) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2□ F Maryland 82 216-22-0927 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ir than "natural", or items 23a or 28a-f shov North Potomac 1 Yes 2 No Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 U.S.A. 12622 Fellowship Way Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black If Yes, Give þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Naval Ordinance permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Item Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Electrician 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia B. Johnson Emmanuel O. Thompson, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type. Print) (Wife) 12622 Fellowship Way, North Potomac, MD Helen A. Thompson Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify) Pleagant View Cem 4/11/09 Gaithersburg, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Funeral Service Licens 21. Signature 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** few years Severe Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Exami burial-tran Due to (or as a consequence of): physician a the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 1 □ Yes 2 □ No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗆 No 1 ☐ Yes of Vital 1 □ Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ➡ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Fafter death. After Division 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide e Hospital 24 hours a e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/7/09 D38262 M D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850

State Registrar

APR 0.8 2009

31. Date filed (Month, Day, Year)



2401 Research Blvd, #330, Rockville, MD

09-02924 Ch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician/ al Examiner	1- For State Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death					
al Examine	1. Decedent's Name (First, Middle,Last) Christy Ann Tracy	Month Day Year 1553 hrs					
	4a. Facility Name (if not institution, give street and number) 22755 Lawrence Ave 4b. City, Town, or Location Leonardtown						
Funeral Director		der 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) June 14.1958 Maryland					
м апу	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary's Leonardto	10d. Inside City Limit 1 X Yes 2 N					
th the Maryland 23a or 28a-f show notified at once	10e. Street and Number 10f. Zip Code 22755 Lawrence Avenue 20650	10g. Citizen of What Country?					
2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu artice event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 12. Was Decedent Ever in U.S. Armed Forces? Tyes 2 X No.	an, Puerto Rican, etc.) White, etc.					
hours after d "natural", or Examiner m ted by Ft	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specific or Dates:	ve kind of work done 16b. Kind of Business/Industry					
Hygiene. 1 other than "naturate Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last) Disabled 18.Moth	Disabled ner's Name (First, Middle, Maiden Surname)					
ould be filed within a marked other the ic event, the Medi	17. Fatters Name (First, Widdle, Last)	Edith Ann Schmidt					
Mental I marked ic event,		lumber or Rural Route Number, City or Town, State, Zip Code)					
nd 2 shou lith and I m 27 is 1 aumatic	Pamela L. Weaver/ Sister 2530 Citrus Lake						
f Healt f Healt If item	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	April 17 2009 Alexandria, Virginia					
permit. Page Department o Important: injury or oth	21. Signature of Funeral Service Licensee 22. Name and Address of Face Mattingley Gard P.O Box 270	diner Funeral Home, P A Leonardtown MD 20650 Segring of respiratory arrest, shock, or heart Approximate Inter					
hysician Madial caminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiovascular	Dogth					
	or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of):						
ted nsit Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
ate be executed hysician and te burial - transit	XUNPENDED AMENDED 23a,PII,27,perME, g891 5,	/14/09 TT					
DIVISION OF VITAL RECOIDES, T.O. DOX 20100. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi-entical Certification: To Be Completed by Physician/Medical Es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Other (Specify)	23d. Date of delivery opic pregnancy Month Day Year					
the att	1 Yes 2 No 9 V Unknown g Unknown	p Part I 23e. Did tobacco use contribute to the cause of death?					
ires that the disigned by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Chronic alcohol abuse	1 Yes 2 No 3 Probably 4 V Unknown					
The law requires ficate has been sign; page 2 should be		24a. Was an autopsy performed? 24b. Were autopsy prior to completion of cause death?					
The land		1 ✓ Yes 2 No 1 ✓ Yes 2 No					
VII. NEW YST VII. VII. VII. VII. VII. VII. VII. VII	25. Was case referred to medical	eath (Check only one) 4 Nursing Home 5 Residence 6 🗸 Other: Scene					
fing Physic funeral director	1 V Yes 2 No 28a Date of Injury 28b. Time of Injury 28c. Injury at V						
LIVISION OF VICAL RECOLUGY, F. C. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detailed in the funeral of the funeral director, page 2 should be detailed in the funeral of the funeral director, page 2 should be detailed to the funeral director, page 2 should be detailed for the funeral director of the fu	Accident Suicide 6 Could not be determined 2 Specify) Natural 5 Pending Investigation 2 Rural Route Number or Rural Route Number or Rural Route Number or Town, State) 28f. Location (Street and Number or Rural Route Number or Town, State)						
To the Hospit within 24 hour To the Funers completely fill		id place, and due to the cause(s) and manner as stated. It occurred at the time, date and place, and due to the cause(s)					
	and manner stated. 29b. Signature and title of certifier 29c. License num O.C.M.E.						
To T with To I		1					
To the with the tenth of the te	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Ball 31. Date filed (Mark Pey, Jean 32 Jegistrar's Signature)	timore, MD 21201					

			. For	State of M		d / Depa	artment of H	lealth and l	_		oie.	
			State Registrar			Cei	rtificate of	Death		leg. No.	0.01	100
	Physicia /Medic		Decedent's Name (First, Middle,	Estelle	Budm	an WAS				5, 2009	Year 5	5:40 A M
	Examin		4a. Facility Name (If not institution,					r Location of Deatl	h	4c. County		21/
			Rockville Nurs 5. Social Security Number		o (In ure	last birthday)	KOCK'	ville If Under 24 Hrs.	8. Date of Birtl		tgomer	e (State or Foreign
X.	Funeral Director		577-36-6726 Usual Residence of Decedent	1 □ M 2 💢 F	81	Yrs.	Months Days	Hours Min.	July 2:	(, Year)	Washi	ington, DC
	Maryland -f show fied at	tor	10a. State 10b. County Maryland Montg	omery	10c. City	Silv	ver Sprin	g				Inside City Limits 1 ☐ Yes 2 No
	th the or 28a e noti)irec	10e. Street and Number		-1		10f. Zip Code			10g. Citizen of W		
	23a cust br	la [3310 N. Leisure			18		906		United		
136	be filed within 72 hours after death with the Maryland hat Hyglene. ad other than "natural"; or ttems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗘 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black Specify.	e - American I k, White, etc. : Whit	
Baltimore, Maryland 21215-0036	nin 72 hou t. tn "natura Medical E	Completed by	15. Decedent' (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or	5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Bu		try
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land	0 = 0 5	To Be (17. Father's Name (First, Middle, I Isadore Bu					Tilli	me (First, Middle, e Silveri	man		
Mary	ind 2 should alth and Men 27 Is marke ar traumatic		19a. Informant's Name/Relationsh H. Joseph Wasse			19b. Maili 11045	ng Address (Street 5 Rutledg	e Drive,	N. Poto	mac, MD	State, Zip Co 20878	ide) 3
nore,	Pages 1 and of Hericut: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		Jud	Place of Disponentery, cre lean Me	osition (Name of matory or other pla emorial G	ardens O	Date 4/06/09	20c. Location -		, State
Baltii	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e one.		21. Signature of Funeral Service I		01008		2. Name and Addre Drchinsky 54 Carrol	Hebrew	Funeral	Home	nr 201	012
	Physician /Medical		23a. Part1 Enler the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each l Respir a. Due to (or as	atory	n. Do noten y Fail	ter the mode of dyi	ing, such as cardia	ac or respiratory a	rest,	Ar Int	pproximate terval Between nset and Death
g H	Examiner	Je.	Sequentially list conditions,	b. Cancer	B la dde	r						
	uted 3 ansit	Examiner	Sequentially list conditions, it ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cancer	of	Colon						
760,	te be executed ysician and ie burial-transit	<u>a</u>	resulting in death) Last	uence of):								
Division or Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Feta	al death 3	□Ectopic pregnand □ Other (specify) _	су			te of delivery onth Da	ay Year
ds, P.	uires that in signed by Id be deta	by	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	underlying cause gi	ven in Part I.		obacco use cont Yes 2 No		cause of death?
Reco	ician: The law requires the certificate has been signed rector, page 2 should be de	Completed							24a. Was auto perfo 1∐ Yes	osv	prior to compl death?	y findings available letion of cause of
ā	ian: rtifica stor, p	Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o			
<u>_</u>	Physic this ce al direc		1 ☐ Yes 2 ☐X No	Hospital: 1 Inpat	ient 2		III 3 DOA		Home 5 ☐ Resi			
n o	ding Pt n. After th funeral	ü.	27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of In (Month, D	jury <i>ay Year)</i>	28b. Time Injury	Wo		28d. Describe	how injury occur	red	
Divisio	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification: To	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be 28e. Place of in	njury - At h etc. <i>(Speci</i>		M 1 1 C]Yes 2 □No	28f. Location (City or To	Street and Numb wn, State)	per or Rural R	Poute Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce									ed. ne cause(s)	
	vithin To th comp	Me	29b. Signature and title of certifie	w v. S	034	N		0047330		29d. Date signe April	6, 20	
	Ψ		30. Name and address of person Thomas V. Josep	l	ala adla /laas	00a) (Tuna	n Drive,	Suite 20	7, Rockv	ille, MD	2085	52
b.	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	trar's Sign							
			ALI IV V	Jan.								

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygh any Injury or other resonance. **Physician** /Medical **Examiner**

Physician

Examiner

Funeral

Director

show

rai", or items 23a or 28a-f shov Examiner must be notified at

Medical

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death with

2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or iter

Maryland 21215-0036

/Medical

10a. State

MD

Director

by Funeral

Completed

Examiner physician and the burial-tran Physician/Medical use as t for been signed by the a should be detached þ Completed certificate has irector, page 2 director. Certification: To Be this s after death.

I Director: A
id in by the fu To the Funeral Dir

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physician;

To the Hospital

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? res 2 No 2 No 1□ Yes 26. Place of Death Check onl one 25. Was case referred to medical Other: 4 Nursing Home Hospital: 1 ☐ Yes 27 No 2 ER/Outpatient 3 DOA 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

9940 FRANKLIN SQUAREDR WHITE MARSH MD-21236

Registrar

Medical

31. Date filed (Month, Day, Year) State

29b. Signature and title of pertifier

32. Registrar's Signature Cenera A.

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

Bullan Jour MD

C.VERGARA-SOARES

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** MARY SHAW WILLIAMS APRIL 2009 3:15 Α /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ROCKVILLE $\mathtt{MONTGOMERY}$ SHADY GROVE ADVENTIST HOSPITAL 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 X F Months Hours Director AUG 3 1917 MD 577-05-3284 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MONTGOMERY POOLESVILLE 1 ☐ Yes 2 🙀 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21130 WESTERLY ROAD 20837 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify. Specify: WHITE 2 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM CLIFTON BROWN EMILY DARBY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5463 AYLOR DR., FREDERICK, MD RODGER WILLIAMS / SON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MONOCACY CEMETERY 4/14/09 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME 21. Signature of Funeral Service Licenses P.O. BOX 86, BARNESVILLE, 20838 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □Yes 2 VNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy s certificate ha lirector, page 2 perform 1 ∐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1, Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manyler of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ARSHAD M.D. 00067782 JAWAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAWAD ARSHAD, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arke APR 0 8 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL **Physician** WOOD D. SHEILA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye APRIL 13 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months MARYLAND 52 217-70-2982 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygiens. Internation the Health and Mertal Hygiens. Internation is marked other than "natural", or items 23a or 28a1 show any Injury or other traumatic event, The "Redical Exprinter must be notified at 14 Yes 2 □ No Director MD PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20720 USA 4622 DEEP WOOD COURT Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 X No timore, Maryland 21215-0036 Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT PRODUCT SUPERVISOR YRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHASE NATHANIEL WOOD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 RODNEY BROWN/SON 4622 DEEP WOOD COURT BOWIE, MARYLAND 20720 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State WASHINGTON NAT'L CEME 4/14/2009 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disection shock, or heart failure MALIGNMAT Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEYMONIA Sequentially list conditions, if any, sacing to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Box 68760. þe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☒No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) o the cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ← nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 4No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Beat 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifie MOD58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, Suite 101A, Greenheit, mD. 20110 7500 Hanover 1D. George MI).

State Registrar APR 0 9 2009

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 1:00 P M 2009 Alcena L. Wilson April 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Heartland Health Center Adelphi If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday. **Funeral** Months Days Hours Min. 1 □ M 2 🐯 F 94 Sept. 14, 1914 Director 215-44-1000 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23a or 28a-f show 1⊈Yes 2 No Director MD Prince George's Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1003 Kings Tree Dr. 20721 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner Food 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caddy Nelson William Richardson Pages 1 and 2 should her ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Dennis Wilson/Son 1003 Kings Tree Dr., Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery: 4/9/2009 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ft. Lincoln Funeral Home eluane de 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Gangrenous lower extremities Sequentially list conditions, if any, leading to initial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consectione) of The law requires that the death certificate be executed Peripheral vascular disease physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Hyperlipidemia attending p for use as t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 No. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Chronic renal failure stage VI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hypotension 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 2 No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State

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il Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and the of fertilier

PR 0 9 2009

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

Kandol

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Rd # Z16, Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 2009 12:25 AM M 5, Louise Widdowson Nancy /Medical 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Princess Anne Somerset Manokin Manor Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 🕱 F 02-13-1924 Director 215-20-4392 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination must be modified at 1XYes 2 □ No Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11974 Edgehill Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [Yes 2] No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar S. Sard Mable L. Talley ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Heaith a
Important: If item 27 Is
any injury or other trau Brenda Howard/daughter 817 Fillmore St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 04/7/2009 Salisbury, Maryland 22. Name and Address of Facility
Hinman Funeral Home
11673 Somerset Ave., Princess Anne, MD 21853 gnature of Funeral 85 vice Licenses M00295 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 ☑ No Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, icate has been significate has been significated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2/1 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 147094

State Registrar

DHMH 17 Rev 1/2001

APR U 8 2009

31. Date filed (Month, Day, Year)

VATEGAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lenn Frank Wil		1- For State Certificate Of			g. No. 2009 1297
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month	n 3. Time of Death
Medical Exami		Glenn F. Williams		April 5, 200	09 11371115
		Tall I delikly status (in the methalicity, give a series and and	4b. City, Town, or Location of Dea	ath	4c. County of Death Prince George's
		Laurel Regional Hospital	Laurel	les 10 Date of Pirt	h(MM/DD/YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			Foreign
Director		212-06-0942 1XM 2 F 40 Yrs		Apr.15	5, 1968 Country) Germany
<u>*</u>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits
ow any					1 x Yes 2 No
Maryland 28a-f show	후	MD Prince George's Laurel 10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
Mar rr 28g	Director		20723		U.S.A.
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		9647 Norfolk Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S	as Decedent of Hispanic Origin? (Specify Yes or No-	
ath w	Funeral	1 Never Married 2 Married Armed Forces? If Y	Yes, specify Cuban, Mexican, Puer		White, etc.
er de		1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: White
irs aft iural'	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind o		16b. Kind of Business/Industry
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136 thin 7	du	11 Drap	ery Installer		Private
5-0(ed wi lygies other	S	17. Father's Name (First, Middle, Last)	18.Mother's Na	me (First, Middle, M	Maiden Surname)
21215-0036 wild be filed within 72 hours after Mental Hygiene. marked other than "natural", ie event, the Medical Examines	Be	Melvin T. Williams, Sr.		. Ponnanc	
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Baltimore, bermit Pages I an Department of Hea Important: If iter injury or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Dispo	other place)		200. Location - City of Town, State
Page nent c		4 Donation 5 Other Specify: Ft. Linco		•	Brentwood, MD
Baltimo permit Page Department o Important: injury or oth			Name and Address of Facility F		
D 80 1.1		Duane Coppeler, per DVR 3	401 Bladensburg	Rd., Bre	entwood, MD 20722 est, shock, or heart Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		c or respiratory am	Between Onset and Death
xaminer	6	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	morrhage		Deall
		h runtured esonhageal	varcies		
	ē	if any, leading to inmediate Oue to (or as a cur sequence of):	Varcico		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
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60, to be executed ysician and burial - transit	edical	X UNPENDED X AMENDED 21 per FD, PI	line a-b, PII,	27,perME,	g890 4/27/09 TT
30, te be sysicia burià	led	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box 68760, death certificate be he attending physici dfor use as the buri	Į į	22h Miss decedent promont in the	Fetal death 3 Ectopic pre	gnancy	Month Day Year
ox 6 ath ce	Sicie	4 Pregnant at time of death 5	Other (Specify)		
BC BC he de:	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did to	obacco use contribute to the cause of death?
that if detacl	by	Liver Cirrhosis; Phencyclindine			s 2 No 3 Probably 4 V Unknown
en sig	ted			24a. Was	an 24b. Were autopsy findings available
aw re	월			autor	psy prior to completion of cause of death?
Rec The I icate I page	Completed			1 Yes	2 No 1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law require as after death. "In Director: After this certificate has been siy led in by the funeral director, page 2 should b	Be (25. Was case referred to medical	26.Place of Death (Che		Residence 6 Other:
F Vi Physi or this	유	1 V Yes 2 No Hospital 1 Inpatient 2 V ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	III 5 BEA 4 110	rsing Home 5	Residence 6 Other:
ding After	Certification:	1 Natural 5 Pending	1 Yes 2 No		
Sio	cati	2 Accident Investigation 28e Place of Injury - At home farm str	reet, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divi	1	Suicide Could not be determined (Specify)	,·,, g, ···	or Town,	
y fill hou		29a Certifier	curred at the time, date and place.	and due to the cau	se(s) and manner as stated.
To the Ho within 24 To the Fo	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig	gation, in my opinion, death occurre	ed at the time, date	e and place, and due to the cause(s)
- 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		The with and	O.C.M.E.	OCME	April 6, 2009
		30. Name and address of person who completed cause of death (Item 23a)			
		Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltim	ore, MD 2120	1
S	tate	31. Date filed (Moore, Day, Year) 22. Registrar's Signature	Ke		

09-02926

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Carlton K. Wright 2009 12977 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1704 hrs Medical Examiner April 12, 2009 CARLTON KEITH WRIGHT 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 6-24-1938 Director 214-36-3967 70 1X M 2 WASTINGTON, D. Yrs Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Any s 23a or 28a-f show : e notified at once 1 Yes 2 X No MD. CHARLES NANJEMOY Fimore, MD 21215-0036

Pages I and 2 should be filted within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Profile if I item 27 is marked of the reform "natural", or item. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4395 PORT TOBACCO ROAD 20662 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces 2 X Married Never Married Yes 2 X No specify Specify: WHITE If Yes, Give Year Yes Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) NAVAL SURFACE WEAPON Elementary/Secondary (0-12) College (1-4 or 5+) U.S.GOVT. HEAVY EQUIPMENT OPERATOR 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VINNIE IOLA MURPHY WILLIAM CARLTON WRIGHT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4395 PORT TOBACCO RD. NANJEMOY, MD. 20662 JOAN WRIGHT-SPOUSE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place)
NANJEMOY CHURCH CEM 1 X Burial 2 Cremation 3 Removal from State .4 - 18 - 09NANJEMOY, MD. Other Specify. Donation 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 M00479 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a Chest and Abdominal Injuries Immediate Cause (Final disease camine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760 23d. Date of deliver IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 ✔ No 3 Probably 4 Unknown ۵. Completed of Vital Records, 24a, Was an 24b. Were autopsy findings available been autopsy prior to completion of cause of has performed? death? page 1 Yes Nο Yes 2 No certificate 26.Place of Death (Check only one) Hospital or Attending Physician: director. 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA Residence 6 this ٩ 1 V Yes No 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Driver in auto/auto collision Apr 12, 2009 1321 hrs Division 1 Natural Yes 2 V No e Funeral Director: Pending death. the Certificati 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State)
Route # 5 @ Route 6, Mechanicsville, Md. determined (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier 29b O.C.M.E. April 13, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

OCME 2006 DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Julia C. Zimmerman 4-14-2009 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Care and Rehab Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F Yrs. **Director** 219-44-4773 2-20-1930 Usual Residence of Decedent filed within 72 hours after death with the Maryfand th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, "in "solical Evan "inc" out by notify of at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 East 3rd Street 21701 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 []Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Own Family permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Clinton Zimmerman Nellie Catherine Castle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Shafer Nephew 6455 Boyers Mill Rd New Market , MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4-18-2009 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Street Frederick, MD 21701 M01176 Approximate Interval Between Onset and Death 23a. Part 1 shock Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final dise or condition ting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. let Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl for use as t IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 r 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performe 2 No 1 ☐ Yes 2 **W**No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ Accident

Box 68760, P.O. I Division of Vital Records,

or Attending Physician: within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death.

> State Registrar

Medical

6 ☐ Could not be

itle of certifier

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and

cause of death (Item 23a) (Type, Print)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued by the desired by the de

29c. License number

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 54 am **Physician** Month EUGENE RONALD /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Har If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F **Director** 51 219-68-9215 MARYLAND MAY 8 1957 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 1709 N. FULTON AVENUE 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) unknown RAILROAD WORKER RAILROAD alth and Mental Hv. 7 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LEONARD L. AMBUSH BESSIE TYLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health David Ambush/Brother 806 Gibbons Rd., Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' Important: If it any injury or o 1 ☐ Burial _2 🖾 Cremation 3 ☐ Removal from State 04-25-09 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY BALTIMORE, MARYLAND re of Funeral Service Ucen _22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 234. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) marde /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical as nding _I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the ad be detached f ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩iiknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 : certificate 2 1 NO vision of Vital 2 PINO 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 Ne ပ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 1 Certification: 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

1970

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	Denartment of Health and Me	•	e	10000
			State Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N	.2009	2980 3. Time of Death
	Physici /Medic			SON	Month D	ay Year 3 20 0	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Deal	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Year		thplace (State or Foreign ountry)
	Director		000 - 00 - 447/ 12M 2□ F 63 Usual Residence of Decedent	Yrs. Montale Baye 1000	09/24/199	45 Wash	ington DC
	aryland show	7	10a. State 10b. County 10c. City, Tow MD Somerset West	n or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Co	***
	ath with	ral D	30420 Revells Neck Road	21890		USA	
920	urs after de al", or items Eval. inver	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri 1 □ Yes 2 ※ No Specify:	ify Yes or No- can, etc.)	14. Race - Ame Black, White Specify: b1	e, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland rial Hygiene. 3d other than "natural", or items 23a or 28a-f show event, I'm Modical Eval.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	unk 16b.	Kind of Business/	Industry unk
land 2	be ad o	To Be C	17. Father's Name (First, Middle, Last) William Anderson	18. Mother's Name (Susie A.		n Surname)	
Mary	and and sand			b. Mailing Address (Street and Number or Rural			Zip Code)
re,	item 2		20a. Method of Disposition 20b. Place of	012 E. Lavale Square B of Disposition (Name of ary, crematory or other place)		MD ocation - City or	Town, State
Balti	permit. Page Department (Important: If any injury or once.		21. Fignature of Funey Service Lice wilder, Director	22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201	655 W. Ba	ltimore	Street
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Dementia	not enter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death 5 years
	/Medical Examiner		resulting in death) Due to (or as a consequence	of):			
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ds, P	law requires that has been signed b 2 should be deta		Part II. Other significant conditions contributing to death but not resulting in	in the underlying cause given in Part I.			the cause of death?
Division of Vital Records,	The law requotate has been page 2 shoul	Completed by	HEPATITIS C POLYARTHROPATHY		24a. Was an autopsy performed?	prior to death?	utopsy findings available
/ital	ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (1 ☐ Yes 2 ☑N Check only one)	o Times	2 □No
of	ding Physician: h. After this certific funeral director,	၉	1		e 5 Residence		city) Prisca
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Divis	lor Atta after de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office 28	f. Location (Street a City or Town, Star	nd Number or Rule)	ural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 M Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination and manner stated.	ie, death occurred at the time, date and place, ar nd/or investigation, in my opinion, death occurred	nd due to the cause(d at the time, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To the complete of the complet	M	29b. Signature and title of ertifier	29c. License number D 25859		ate signed (Mont	h, Day, Year)
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) DAVID MATHIS MD 30 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(Type, Print) 420 REVELLS NE	ERICR	D, WES	21890 FOVER, 17]
	Registr	ar	APR 1 7 2009 Grave B.	barles			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #3 per MD 8890 4723/09 TT/#18perTNF, 8891 575/09 WS State of Maryland / Department of Health and Mental Hygrene? 0 0 0 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month A^{M} 3:05 FAY C BACOTE 4/19/2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death PRINCE GEORGE"S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Months Hours 1 □ M 2**X**□ F Philadelphia,PA 81 8/27/1927 183-22-4054 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 Yes 2 No Maryland Prince George's Capital Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6700 Arlene Drive 20743 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Teacher P. G. County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mainwright

Physician /Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be motified at once.

Completed by Funeral Director

and

or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director, within 24 hours after death To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

o Be	17. Father's Name (First, Middle, La Alonzo Cannon	st)		18. Mother's Name (First, Middle, Maiden Surname) Dora Hainwright Dora Hainwright						
10	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Stree	·		or Town, State, 2	Zip Code)			
	Arthur F. Bacote	/ Husband	6700 Arlene Da	rive Capita	1 Heights	s. Marvla	and 20743			
	20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other pla			Location - City or				
	1 🙀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other <i>(Sp</i> e	☐ Removal from State	rmony Memorial		2009 Lar	ndover, 1	Maryland			
	21. Signature of Funeral Service Lic	censee	22. Name and Addr	ess of FacilitPope						
	Kuta	Sand MULO	55 5538 Mar11	oro Pike F	orestvill	Le, Mary	land 20747			
	23a. Part 1. Enfer the disease, or co shock, or heart failure. List on	omplications that caused the dea ily one cause on each line.	th. Do not enter the mode of dy	ing, such as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death			
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nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conser	querice oi).			:				
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Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 D Ectopic pregnan			23d. Date of delivery Month Day Year				
/ Ph	Part II. Other significant condition	s contributing to death but not re	sulting in the underlying cause g	ven in Part I.	23e. Did tobacco	o use contribute to	the cause of death?			
q pa	CHRONIC OBSTRUCT	TIVE PULMONARY	DISEASE		1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown			
plet	CORONARY ARTERY	DISEASE			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of			
Com	DIABETES MELLITU	JS			performed?	death?	s 2 No			
Be (25. Was case referred to medical examiner?			26. Place of Death (Check only one)					
2	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 I	☐ ER/Outpatient 3 ☐ DOA	her: 4 Nursing Home			ecify)			
ation:	27. Manner of Death 1	jury occurred								
Medical Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	and Number or R ate)	ural Route Number,							
dical		Physician: To the best of my kr kaminer: On the basis of examin and manner stated.								
Me	29b. Signature and title of certifier		29c. Licer	se number	29d. [Date signed (Mon	th, Day, Year)			
	1 7 20	-/) +=	-	ENDIZ		111 . 32				

DHMH 17 Rev 1/2001

State

Registrar

30. Name and add

31. Date filed (Month, Day, Year)

APR 2 3 2009

H. FORRESTER

LEIGHTON

7500 Hanover Pkwy Suite 204 Greenbelt, Maryland 20770

ss of person who completed cause of death-(Item 23a) (Type, Print)

32. Registrar's S

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** April 19, Eleanor Elizabeth Bealefeld 11:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Hours | Min. | Nov. 26, 215 Poplar Avenue Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 6. 1921 **Funeral** 1 M 2 F Months 87 216-16-3533 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Martical Evamines must be required. 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Poplar Avenue 21061 United States Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □Yes 2 X No Specify: White Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Gable Annie Davis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick H. Bealefeld - Hus. <u> 215 Poplar Avenue, Glen Burnie, MD 21061</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
West | Arundel 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Dination 5 □ Other (Specify) Odenton, MD 04/22/2009 Crematory 104/22/2009 Crematory 22. Name an Address of Facility Ambrose Funeral Home, Inc. 21. Sign June of June of Service Liceose 1328 Sulphur Spring Rd., Arbutus, MD 21227 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** JUM ac year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to impediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the should be detached certificate ha this certific al director, After neral Director: / within 24 hours a To the Funeral D completely filled is

> State Registrar

31. Date filed (Month, Day, Year) APR 2 3 2009

27. Manner of Death

1 Naturai

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRIDITAL ATTURI

5 Pending investigation

6 ☐ Could not be

8109 14 due 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

50470

28d. Describe how injury occurred

ascarleur, MD 21122

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2C

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** April 2110 p M 19 2009 VIVIAN HENDRIETH BRITTEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAVRE DE GRACE
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. HARFORD CO HARFORD MEMORIAL HOSPITAL 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Months 1 □ M 2 🛛 F 72 Director SEPT 4 1936 ALABAMA 262-54-0886 Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show r than "natural", or items 23a or 28a-f shov the M. dical Examiner must be notified at 1 ☐ Yes 2 No Director ABERDEEN MARYLAND HARFORD CO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 39 HILLMAN CT. 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2000No Specify Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 12yrs N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked of be ARCHIE HENDRIETH BESSIE HARRIS other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Samuel A. Britten Sr./Husband 39 Hillman Ct., Aberdeen, Md., 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State ARLINGTON NATL. 05-06-09 ARLINGTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Sur at re of Fune al Service License 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S.PHILADELPHIA BLVD, ABERDEEN, MD 21001 Part1. Enter the disease, or co shock, or heart failure. List on Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a sequence of) Examiner bunial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 (No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an aw autopsy perform The page 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 12 Inpatient Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending OK Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Records Vital Division Hospital

Baltimore,

State Registrar

completely

(Check only

29b. Signature and title of certifier

MPP SAPEAKE ERCHE 00 32. Registrar Signatu 31. Date filed (Month, Day, Year) APR 2 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

100 63220

29d. Date signed (Month, Day, Year)

7009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 1617 BOOKER CT. Funeral Director Director 10a. State MYRTLE BROWN 4b. City, Town, or Location of Death Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death Ac. Country of Death Ac. Country of Death Ac. Country of Death N/A 1 Under 1 Year Month Day Year Ab. City, Town, or Location of Death If Under 1 Year Month Day Year Ac. Country of Death N/A 1 Under 1 Year Month Day Year Ac. Country of Death N/A 1 Under 1 Year Month Day Hours Min. JULY 8 1945 VIRGI: 10a. State 10b. Country 10c. City, Town or Location	Time of Death 5:32 a M
MYRTLE BROWN April 22 2009	5:32 a ^M
4a. Facility Name (If not institution, give street and number) 1617 BOOKER CT. 5. Social Security Number 212-44-4219 Usual Residence of Decedent 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min. JULY 8 1945 VIRGINATION JULY 8 1945 VIRGIN	
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Usual Residence of Decedent	
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Total Street and Number	
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Elementary/Secondary (0-12) College (1-4or 5+) 12yrs LPN HEALTH	
De 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
PROPOSE TO THE PROPOS	
JERAMIAH BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Andre Brown (Son	9)
Andre Brown/Son 1617 Bakbury Ct., Baltimore, Maryland 2121	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Some cemetery, crematory or other place)	
Andre Brown/Son 1617 Bakbury Ct., Baltimore, Maryland 2121 20a. Method of Disposition 15 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Fune all Service Liversee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P	MD
WILLIAM C BROWN COMMUNITY FUNERAL HOME P	.A.
23 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Applications that caused the death.	roximate val Between
Physician Immediate Cause (Final disease or condition a Company of the Company of	et and Death
/Medical resulting in death) Due to (or as a consequence of):	
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24a. Was an autopsy fin performed? 1 Yes 2 No 3 Probably	ndings available
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25. Was case referred to medical examiner? 1 Ves 2 No.	
1 Pes 2 No rospital. 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Chatural 5 Pending (Month, Day, Year) 28b. Time of Injury 4 Work? 1 Pending investigation 4 Injury 4 Injury 5 Pending investigation 6 Injury 7 Injury 8 Injury at Work? 8 Injury at Work? 9 Injury at Work? 9 Injury at Work? 9 Injury at Work?	
1 Yes 2 No Norsing Home 5 Residence 6 Other (Specify)	te Number,
City or Town, State)	
The state of the	cause(s)
one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey,	Year)
Mun Mariel MD DIMAID 2/12/12	1
30. Name and address of person who completed cause of death (Item 23a)/(Type, Print)	
TOUN WITHING 4100 MI CHANGEST DIVITO, MIN 21218	×
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

29b. Signature and title of certifier

30. Nome and address of person who completed cause Russell Alexander MD. Assistant Me

State Registrar

31. Date filed (Month, Day, Year) 2009

Registrar's Signature

death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 21, 2009

986 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ARBOUR RANCES 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner BALTI MIKE BALTI MURE SECOUR Health 1879m If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 214-20-2358 Director 01-20-Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itams 23a or 28e-f show any injury or other traumatic evant, the Medical Examinat must be notified at once. Ballimore City 1 Yes 2 No Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rove St. Ballymore, My 21216 USA 740 'OPLar filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 P No Specify: δ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene, int: If item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame)

Mary Lorina Proctor 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 28 Janic 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 Removal from State Mem. * 4 ☐ Donation 5 ☐ Other (Specify) King 21. Signature of Funeral Service Licensee 22. Name and Address of Facility neral Home P.F. 216 W. North 23a. Part) Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TOWN /Medical nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last gyance of): Examiner been signed by the attending physiclan and should be detached for use as the burial-transit The law requires that the death certificate be executed (or as a conse Mence of) Due to Division of Vital Records, P.O. Box 68760, now Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 : autopsy performed? 2 🗆 No 2)(1 ☐ Yes 1 ☐ Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 📩 Inpatient Certification; To 1 🗌 Yes 2√2 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of anh 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 W 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () () 9 2987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lois Oropeza Chaloux Month April ÎB, 2009 8:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkridge Howard 7130 Ducketts Lane -104 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/23/1917 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 □ 7F 003-20-7654 91 Director Kansas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Exp., incl. ust be retiffed at once. 1 ☐Yes 2 No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7130 Ducketts Lane - 104 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1. Yes 2 □ No Specify Specify: White Þ 3 -Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Registered Nurse</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augustin oropeza Herlinda Anaya ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Chaloux / Son 6108 Lori Lane, Elkridge, Maryland, 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4/22/2009 | Glen Burnie, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi P.O. Box 68760x Due to (or as a consequence of) attending physician for use as the burial Physician/Medical CERTIFICATION APPROVED BY IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? spital or Attending Phours after death.
neral Director: After 'y filled in by the funera 28d. Describe how injury occurred 1 ☐ Natural 2 ☑ Accident 5 Pending investigation Injury 7,2008 UNKNOWN 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Medical

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 2 3 2009

Kevin Carlson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10700

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0-53636

29d. Date signed (Month, Day, Year)

			1 - State Registrar	State of Mary		irtment of F		and Mental Hy	giene Reg. No. 2 (09	12988
F	Physici	an	1. Decedent's Name (First, Middle, Last)		<u>(</u>		1	2. Date of Do		Year_	3. Time of Death
	/Medic	al 🛚	Aa. Facility Name (If not institution, give str	eet and number)		nPbé!	Location	April of Death	4c. County		4: 26 PM
The same of	Examin	er	The Johns Hopkins Hos			Baltimore					
	Funeral Director		5. Social Security Number 6. Sex 1. X	7. Age (In	yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bi Min. (Month, D May 21	rth ay, Year) 1926		ace (State or Foreign V) Vland
200	\$		Usual Residence of Decedent 10a. State 10b. County	1.10	c. City, Town or Loc	notice.)	Od. Inside City Limits
	Maryla I-f shor ied at	tor	10a. State 10b. County Maryland Baltimor		Dunda						1 ☐ Yes 2 ☐XNo
	ith the or 283 e notif	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen of \		y?
	eath w	Funeral	6817 Boston Avenue	. Was Decedent Ever	in IIS 13 V		1222	ain? (Specify Yes or No	US 14 Bac	SA ce - America	n Indian
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 XMarried 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	gin? (Specify Yes or No 1, Puerto Rican, etc.)	Blac Specif	ck, White, et	C.
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Baltimore, Maryland 21215-0036	al Hygi al Other vent, ti	Be C	17. Father's Name (First, Middle, Last)	11				er's Name (First, Middl rgaret Shay		me)	
ryla	hould to d Ment marked natic e	ပ	Raymond Hugh Campbe		19b. Mailir	a Address (Street		er or Rural Route Num		State, Zip (Code)
Ma	alth an 27 is 1		Antoinette Campbell	wife				e, Dundalk,			*
ore,	ges 1 at of He		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re			natory or other plac		Aprilate 22,	20c. Location		
E E	artmen artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licenses.		Bayview			2009	Baltimo	•	aryland
Ba	permi Depar Impor any ir once.		Chithony Ci	muell	as 1	110 SOTTE	ers P	al Home Of oint Road,	Dundalk	,P.A. ,Md. 2	21222
		W J	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	ations that caused the cause on each line.	^^ :			cardiac or respiratory			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Acute Due to (or as a co	nsequence of):	oGeni	Dus	LEUKe	mia		MONTH
	Examiner	<u>.</u>	Sequentially list conditions, b.								
	ted nsit	Examiner	Sequentially list conditions, if a y, each g to immediate cause. Enter Underlying Cause (Disease or injury	Dille to (bride a co	nsequence or,						
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8760,	cate be ohysicia the bu	edical	d.								
89 X	death certifica attending pt d for use as f	an/M	23b. Was decedent pregnant	c. If yes, outcome of pr		Ectopic pregnanc			11	te of deliver	у
O. Box	ie death the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time 9 Unknown		Other (specify)	y		Mo	onth [Day Year
σ.	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions conti	ibuting to death but no	ot resulting in the u	nderlying cause gi	ven in Part		./		e cause of death?
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ıta	ysician: The lars certificate has director, page 2	Be C	25. Was case referred to medical examiner?			·		e of Death (Check only		I L les	
of \	Physic this ce ral dire	မ	1 ☐ Yes 2 ☑ No ☐ Ho 27. Manner of Death	spital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 🗆 NC	ursing Home 5 Res	idence 6 🗆 Oth	ner (Specify)	
ion	nding f ath. :: After :e fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	Worl	k? Yes 2 □		,,		
Division of Vital Records,	l or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - building, etc. (S)	At home, farm, streecify)	eet, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rural	Route Number,
_	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifier 1 Certifying Physic (check only 2 Medical Examine	cian: To the best of my	knowledge, death	occurred at the tir	ne, date ar	nd place, and due to the ath occurred at the time	e cause(s) and m	anner as sta	ated.
	the Ho hin 24 the Fu mplete	Medical	29b. Signature and title of certifier	and manner stated.	- 1	29c. License		ain occurred at the time			
	vvii o o	~) MV		MP/PHO	0.0	06-	7327	APRIL		2009
			30. Name and address of person who cor	npleted cause of death					, .		-
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature			600 North W	offe St, Ba	itimore	е, мр., 21287
	Registi		APR 2 3 2009	Cerenta &	1. park	1					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:00 P M Dorothy Clements Anne April 20. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air If Under 1 Year If Under 24 Hrs. 923 Side Hill Drive Harford 9. Birthplace (State or Foreign Country) 1925 Maryland Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Director 24, 220-46-7136 84 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Madical Exercitive a unit by notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 923 Side Hill Drive 21015 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No à Specify: 3 ₩ Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Margaret (unk) Miller Edward Gorsuch Duncan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau once. 503 Likeston Court, Severna Park, MD 21146 Duncan S. Clements / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-24-09 4 Donation 5 Dother (Specify) Crownsville, Maryland Crownsville Veterans Cem. 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Full eral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SCHOMIC CANDIOMYOPMITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HYPEN TONSION the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. DIABETES by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONA INFANCE 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed TUNE DISONDAM 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Director: / 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide in 24 hours.
the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated. within 2 29b. Signature and tid 29c. License number 29d. Date signed (Month, Day, Year) 440769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURMO 2227 OLD EMMORNIN RD SUITE 220 Dollmaflen 32. Registrar's signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per FH g890 4/23/09 ITI
State of Maryland, Department of Health and Mental Hygiene.

				1 - For State Registrar	State of Mary		ertificate of L		,	giene Reg. No.	2009	12990
		Physici	an	Decedent's Name (First, Middle, Jean Caldwell C	<i>'</i>				2. Date of Dea Month	Dav	Year	3. Time of Death
	A. A. A. A. A. A. A. A. A. A. A. A. A. A	/Medio		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death	April 2		2009 County of Death	9:33 p ^M
1	كمس	LAGIIIII		Stella Maris Ho	ospice		Time	onium			Baltimo	re
		Funeral Director		237-44-8698	. Sex 1 □ M 2 T F 7. Age (In	yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec. 1	y, Year)	9. Birthp Coun N	lace (State or Foreign try) C
		land ow		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or l	ocation				10	Od. Inside City Limits
		a-f sh	ctor	MD Baltir	nore	Timo	nium					1 □Yes 2 No
		th with the 23a or 28 ast be no	Funeral Director	10e. Street and Number 205 Belmont For	rest Ct. #407		10f. Zip Code 21093	}		10g. Citiz	en of What Coun	try?
	5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Madical Extentive Inter	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 □ Vo	ispanic Origin? (Spa n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White, e Specify:	
33 р.ш	21	within 72 h ene. than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Giv	edent's Usual Occupa re kind of work done a DO NOT use retired	during most of workii)	ng			byterian
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2009	lary	2 should and Mer is marke aumatic	_	19a. Informant's Name/Relationship		1	ling Address (Street a			-		
		1 and 2 Health em 27 i		Lawrence M. Cl								m, MD 2109
21	Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 Burial 2 Tremation 3	I hemoval from State		oosition (Name of ematory or other place	i	ate		ation - City or To	
APRIL	ij	permit. Pages Department of Important: If it any injury or once.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Fun Sapies, Li	_**		Cremator 22. Name and Addres	s of Facility			Burnie	
AP!	ñ	Per Per any any		Michael J. F		1	Lemmon F	uneral Ho	ome of	Dula	ney Vall	ey, Inc.
				23a. Part 1. Enter the disease, or co shock, or heart failure. List on		death. Do not e	nter the mode of dyin	g, such as cardiac c	r respiratory ar	rrest,		Approximate Interval Between
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		/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):						
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	s, P.	ss that gned by e deta	y Ph	Part II. Other significant conditions	s contributing to death but not	resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco us	e contribute to the	e cause of death?
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AN	æ	The law requires t cate has been signe page 2 should be o	Completed						24a. Was a autop perfor 1 □ Yes	rmed?	24b. Were autop prior to con death? 1 ☐ Yes	osy findings available npletion of cause of 2 No
7	Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				
	o	iding Physician: th. After this certifical funeral director,	n: To	1 ☐ Yes 2 🗶 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea		of 28c. Injury	4 LI Nursing Hor	ne 5 ☐ Resid 28d. Describe h			HOSPICE
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(0	8	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) X Nurse Pra	Physician: To the best of my caminer: On the basis of exan Ctitaloner	knowledge, dea mination and/or	investigation, in my or	oinion, death occurre	and due to the ed at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	_	o N will will be con	2	29b. Signature and title of certifier	2 Olace		29c. License	number		29d. Date ; i	signed (Month, E	Day, Year)
		۸ .		30. Name and address of person wh	SCIVI	(Item 23a) (Tues	75/4	7176		41	24200	7
		"> √		JACKIE JONES,			LLEY RD.	TIMONIUM	, MD 21	093		
		Star Registra		31. Date filed (Month, Day, Year)	32 Registrar's Si					- : -		

	1	For State Registrar		,	Department of Certificate of		ia momani	Reg. No	000	10	129	Q
		. Decedent's Name (First, Middle, La	ast)				2. Date of D	eath		3.2	3. Time of D	eath
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Funeral Director	10	0e. Street and Number			10f. Zip Code			_	itizen of Wh		•	
<u> </u>	2	2300 Dulaney Vall	ey Road F	004		21093		Un	ited	Stat	tes	
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by F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X	No	1 □Yes ŽŽNo				Specify:		nite	
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Completed		12	College (1-4or 5)+)	Supervi	sor		Ва	ltimo	re (County	
Be (17	7. Father's Name (First, Middle, Last	")			18. Mother's	Name (First, Middle	e, Maider	n Surname,)		
ျှ		Milliam Downey				Ida Ke	erstetter					
	31	9a. Informant's Name/Relationship		- 1	o. Mailing Address (Stree						,	
Ŀ	1		Daughter)		001 Cloverl		Phoeni				21131	
	120	0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		of Disposition (Name of erry, crematory or other pla	210.	ril 24,		ocation - C	•		
	-	4 □ Donation 5 □ Other (Special		Evans	Funeral Ch	- '	009	Fo	rest	Hill	L, Mary	Lai
	2	1. Signature of Funeral Service Lice	orsee OAK	1 -	22. Name and Addr	ess of Facility						
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ı	In	23a. Part / Four the dise / e, or om show, or heart fail in List only mmedia · Cause Fin !			not enter the mode of dy	ring, such as car	rdiac or respiratory		&Crem Maryl	atio and	21093 Approximate Interval Between	en
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Amend 10e, per Fh G890 4/23/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Eiler Elizaheth PM Margarite Z 2009 1517 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | No. 1 6 1925 Bayvicia Medical Center

6. Sex 7. Age (In yrs. last birthday) Johns Heokins
5. Social Security Number Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 ☐ Director 83 212-24-8514 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 □No 28a-f Maryland Baltimore Dunda1k 10e. Street and Number **7403** 10f. Zip Code 10g. Citizen of What Country? 23a or 7903 Edsworth Road 21222 U.S.A. Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or items 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Tes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White ģ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William С. Jungblut Madeline ဂ Sommerfeld 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any Injury or other trau once. 423 Terhune Road Princeton, NJ. 08540 Ronald Bounds (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Apr^{Date} 23. 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Baltimore, Maryland Crematory Inc 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Fluneral Service L 1005 Dundalk Ave. Baltimore, Maryland 2122 23a. Fart1./Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx ate erv Between and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Anoxia /Medical Due to (or as a consequence of): Examiner otracerebral Hemorrhage Eague Itially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Fall burial-trar P.O. Box 68760, Due to (or as a consequence of) the attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 ☐ Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 X No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 4-20-2009 unknown 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide Fall 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dungalk 7403 Edsworth Rd. Home 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JELPL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	ite of Maryla		epartment of F Certificate of .			ene 009	12993
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
4	/Medic Examir	al	4a. Facility Name (If not institution, give street a	and number)		4h City Town o	r Location of Death	04	10 200 4c. County of Dea	9 12 10 AM
	Examm	er	University of Manylan		1 Cenk	er Balh	more		40. County of Bea	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yr. 30	s. <i>last birthd</i> Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 21	Year) Co	thplace (State or Foreign buntry) SHINGTON, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town o	r Location		OCE	1970 1111	10d. Inside City Limits
	Maryla a-f sho	tor	MD WASHINGTON	1.001.0		ERSTOWN				12 Yes 2 □ No
	or 28%	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ns 23a	Funeral	25½ WEST FRANKLIN STR 11. Marital Status 12. Wa	s Decedent Ever in	U.S.	21740 13. Was Decedent of H	lispanic Origin? (Sr		USA 14. Race - Ame	erican Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event has must be possible and once.	by	Arried 1 ☑ Never Married 2 ☐ Married 1 ☐	ned Forces?]Yes 2 🔀 No es, Give ar or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 対 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc.
15-(in 72 h n "natu Acdical	plete	15. Decedent's Education (Specify only highest grade comp		10	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	during most of work	ing 1	6b. Kind of Business	/Industry
212	filed with Hygiene. other than	Completed	Elementary/Secondary (0-12) Col 11th	lege (1-4or 5+)		HIER	·	:	PRIVATE	
and	d be filk ental H ced oth c even	Be	17. Father's Name (First, Middle, Last) THOMAS M. COEFIELD				18. Mother's Nam	e (First, Middle, M ORD	aiden Surname)	
Maryland	2 shoul and M is marl aumati	ᅀ	19a. Informant's Name/Relationship (Type. Prin	nt)	19b. M	lailing Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
	1 and 1 Health em 27	3	GOLDIE FORD/MOTHER 20a. Method of Disposition	20h		B WOODPOIN			OWN, MARYLA	
Baltimore,	it. Pages rtment of rtant: If its njury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State	cemetery,	crematory or other place ALE CREMAT(ORY 4/20	/2009 R	IVERDALE,M	ARYLAND
Ва	Depa Impo any I		21. Survive of Furl ral Service Licensee			22. Name and Address 7474 LAND(INS FUNERA R,MARYLAND	
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the dea e on each line.	ath. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
plan :	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ON ISCho		Cardio	myopad	ny		
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60,	ifficate be executed g physician and as the burial-transit			ue to (or as a conse	quence of):					
68760,		ledical	d							
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S, D.	uires that the de signed by the d be detached	by Ph	Part II. Other significant conditions contributing	g to death but not re	sulting in th	e underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
örd	require been si should b	eted							2 No 3 P	robably 4 🗌 Unknown
Division of Vital Records,	Physician: The law r this certificate has l ral director, page 2 s	Completed						24a. Was an autopsy perform	prior to death?	Itopsy findings available completion of cause of
Ţ	ysicia is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital	1 ☑ Inpatient 2 □	☐ ER/Outpa	itient 3 DOA Othe	25.	h <i>(Check only one,</i> ome 5 □ Residen	oce 6 ☐Other (Spe	cify)
ion o	ath. r: After the funeral	ation: 1	27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	Date of Injury (Month, Day, Year)	28b. Tim Injui	ry Work		28d. Describe how		
Divis	tal or Atters after de al Directo ed in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At h building, etc. (Spec	nome, farm, ify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ro State)	ural Route Number,
	the Hospi nin 24 hou the Funer npletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or and	To the best of my kn the basis of examin d manner stated.	nowledge, di nation and/o	eath occurred at the tin r investigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, dat	use(s) and manner a te and place, and due	s stated. to the cause(s)
•	Vitl COL	2	29b. Signature and title of certifier	00	MN	29c. License			d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who complete	d cause of death (Ite	m 23a) (Typ	oe. Print)	6435P189		1 10	2007
	Sta	e.	Rebecca Howell 22 31. Date filed (Month, Day, Year)	5. Green 32. Registrar's Sign	ne St lature	Baltimo	ve MI) 2	1230		
	Registra		150 9 3 2009 Z	men d.	pa	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Oldio or inc	ar y rarra / E	Certifica			vieritai riy	Reg. No.	0000	120	194
	Physici	an	1. Decedent's Name (First, Middle		0 1				2. Date of Dea	ath Day	y oo Xear	3. Time of	
A.	/Medic	al	·	othy Lou	Gard						^y 2009 ^{ear}	6:45	Рм
	Examin	er	4a. Facility Name (If not institution, College Manor A	-	inα		ty, Town, or L Luther	ocation of Death			County of Death Baltimor	0	
	Funeral				e (In yrs. last bir	thday) If Und	der 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birtho	place (State o	or Foreign
	Director		213-28-7089 Usual Residence of Decedent	1፟፟ M 2□F	76	Yrs. Month	ns Days	Hours Min.	8. Date of Birt (Month, Da 10-13-	1932	. Mar	yland	
	/land		10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside Ci	ity Limits
	a-f st	ctor	MD		Balt	imore						t¥∐Yes	2□No
	or 28	Director	10e. Street and Number			10f.	Zip Code	-		10g. Cit	izen of What Cour	ntry?	
	ath w	rai	4 West Lee Stre					1201			nited St	ates	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examiner met be rectified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent E Armed Forces? 1 □ Yes 2 🔀 N		13. Was De	cedent of Hisp pecify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		 Race - Americ Black, White, or 		
036	urs af	by	3 ☐ Widowed 4 K XDivorced	If Yes, Give Year or Dates:	.0	1 □Yes	2 K No	Specify:			Specify:	White	
5-0	72 ho	Completed	15. Decedent' (Specify only highes	Education	16a.	Decedent's U	sual Occupati	ion	ina	16b. Ki	ind of Business/Inc		
21	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)			ring most of work	ilig	М.	0		
5	iled w Hygie ther t	S	17. Father's Name (First, Middle, L	a ct)		Bookke		8. Mother's Nam	a /First Middle		ving Com	pany	
lan	d be f ental ked o	To Be	Earl Murphy	101)					P. Hobbs		Surname		
ary	shoul and M marl umati	ř	19a. Informant's Name/Relationsh	p (Type. Print)	19b.	Mailing Addre	ess (Street an				or Town, State, Zip	Code)	
ž	and 2 saith a 27 is er tra		Horatio E. Phil	ip - Compani							yland 21		
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation	Dameyel from State	20b. Place of cemeter	Disposition (A y, crematory o	lame of r other place)		Date	20c. Lo	ocation - City or To	wn, State	
Ë	Pag tment tant: I		4 □ Donation 5 □ Other (Sp	ecify)				c. 04-2	1-09	E1kr	idge, Ma	ryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffied at once.		21. Signature of Funeral Service L	censee M00053	3						n Funera Elkridge		
			23a. Part 1. Enter the disease, or o	omplications that caused	the death. Do r		-				Litti idge	Approximate Interval Bet	
Charles	Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	-a. Gliobl	astoma		lti for	we_			3	Onset and I	Death 15
-	Examiner		Sequentially list conditions	Due to (or as a	a consequence o	of):							
77	led isit	Examiner	Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury	Die to (or es a	s consequence d	10:							
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68760,	rtificate be executed ng physician and as the burial-transit			d									
		Medical	IF FEMALE:										
Вох	eath cer attendir for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		3 🗆 Ectopia	c pregnancy			1 2	23d. Date of delive	•	(a
0	The law requires that the death ce the has been signed by the attendinge 2 should be detached for use	Physician/	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other	(specify)				WOTH	Day Y	/ear
ر, ح	res that signed t be deta	by PI	Part II. Other significant condition	s contributing to death bu	t not resulting in	the underlying	g cause given	in Part I.	23e. Did to	bacco u	se contribute to th	e cause of d	eath?
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ō	Phys er this eral di	5.70	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inpatie	nt 2 ER/Out	tpatient 3 🗌 i	DOA	4 L Nursing Ho	me 5 Resid		Other (Specify	/)	
ion	nding Phy ath. r: After thi e funeral (atior	1XNatural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injur (Month, Day tion	(Year) Ir	njury M	28c. Injury a Work? 1 □ Ye	s 2 🗆 No	zou. Describe i	ow mjun	y occurred		
<u>Vis</u>	or Attending Physician: ifter death. Director: After this certification by the funeral director, in by the funeral director, in the funeral director.	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, far	m, street, facto	ory, office		28f. Location (S City or Town	treet and	d Number or Rura	l Route Num	ber,
	ital o									·			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number									tated. the cause(s))	
	To th To th comp	Me	29b. Signature and title of certifier	0111		2	9c. License n	umber	2	29d. Dat	e signed (Month, I	Day, Year)	
			beislu !	stalling mo			0006	4099	1	Mind	20, 200	9	
			30. Name and address of person w	no completed chuse of de	eath (Item 23a) (1 010-	1			
	-610	0	31. Date filed (Month, Day, Year)	Street Sul	r's Signature	Ber	ninae	Marylanc	2123				
	Stat Registra		APR 2 3 2009	Deneura 1	1. par	Kel		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apri 2:00 A **Physician** Willie Mae /Medical 4c. County of De 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** South Carolina Months Days 1 □ M 2 🗗 F 64 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** Maryland 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number or items 23a 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: Specify: Black 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 Be Completed by 3 ₩idowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) Kri Vacte College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gara Gra ပ 19b. Mailing Address (Street and Number or Flyal Route Number, City or Town, State, Zip Code) 21218 1809 E. 32Nd St. Baltiman Maryland of Health a item 27 is Juanita Sutter 20c. Location - City or Town, State 20a. Method of Disposition ± 0 = 0 1 Burial 2 ☐ Cremation Owings Mills, Maryland permit. Page Department o Important: If any Injury or once. 3 Removal from State Gamison Forest Vel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown filled in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed in by the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
Autural
2 Accident 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** HARRIS ATKELING /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Manor Care - Woodbridge Valley Catousville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days 213-26-174 Director Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director Marylan 10g. Citizen of What Country? 21217 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Completed by 3 Widowed 4 Divorced n and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kearl Lewis E ပ္ 19b. Mailing Address (Street and Number or Rural Route Number 19a. Informant's Name/Relationship (Type. Print) City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trauonce. 2222 Mt. Koyal Terrace Casandra Wilkins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic arcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical attending p SE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 **2**No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No cate has t autopsy performed? Yes 2 40 After this certificate I funeral director, page 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

BUSINESS

Registrar's Signature

CENTER

DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 000 . /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death enver more N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 9. Birthplace (State or Foreign Country)
Virginia 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F 38 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Maricel Extrainment and be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Director 1XYes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Eutaw Place, Apt. 222 21217 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Specify: **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Woodley Martha Cottman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Calvin Harris - son 1322 Gittings Avenue, Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/23/2009 Baltimore, MD 21. Signature of Funeral Society Consee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onser and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Completed by Physician/Medical as the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) the detached 9 Unknown b Part II, Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas certificate 2 **4**No 1 ☐ Yes 2 **9N**0 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) r this c 21/10 Hospital: 1 ☐ Yes Medical Certification: To 1 Dinpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death.

I Director: A id in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 2 3 2009

Dtrau55

30. Name and address of person who completed cause of death

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For						nd Mental H	_		_		
		1 - For State Registrar			Ce	rtificate of	Death		Reg. No. 20	09 12998	j		
Physic	sian	1. Decedent's Name (First, Min	11					2. Date of I	Death Day	3. Time of Death			
/Med		1-sabel	Harmon					April		Year 4:23 PM	_		
Exam	iner	4a. Facility Name (If not institu	/			4b. City, Town, o		Deam	4c. County	N/A			
Funera		5. Social Security Number	6. Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 2		Birth Day Year	9 Birthplace (State or Foreign	-		
Directo		217-28-7835	1 M 2 F	77	Yrs.	IVIOTITIS Days	Hours	MAR 1	1 ^{ay,} 1932	Maryland			
and		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits			
Mary a-f she	ţoţ	MD	N/A	В	altimo	re				X Yes 2 □ No			
th the	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of V				
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23a or 28a-f show ant, the Medical Examfraer rest be notified in	Funeral Director	5322 Beaufort		mt. II	S 140	21215		-0 (Cit.V	US				
ter de	Fun	11. Marital Status 1X Never Married 2 □ N	12. Was Decedent Armed Forces?	,	.5. 13.	If Yes, specify Cub	an, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No- 14. Hac Blac	e - American Indian, ck, White, etc.			
036 ours at	þ	3 ☐ Widowed 4 ☐ Divord	I If Yes, Give			1 □Yes 2 XX No	Specify:		Specify	White			
21215-0036 d within 72 hours aft giene. er than "natural", or , the "foot Experi	Completed	15. Deced (Specify only hig	lent's Education hest grade completed)		(Give	dent's Usual Occu kind of work done	during most	of working	16b. Kind of Bu	usiness/Industry			
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examples 1.00 is not the prelified in		Minnie Martin 20a. Method of Disposition	Guardian	20b. F		psition (Name of matory or other pla		e, Baltim		21225 City or Town, State	_		
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Physiciar	7	23a. Part 1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition	or complications that cause ist only one cause on each li	. /	-	ter the mode of dyi	ing, such as c	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death			
/Medica		resulting in death)	Due to (or as			- 0 1				2	_		
Examine		Sequentially list conditions	b. Myo Co		al _	On furcher	1			2 hours			
uted uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				Discuse				20 4015	3		
ate be executed hysician and he burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):	-3-4				/			
. Box 68760, expected death certificate be executed eattending physician and dror use as the burial-transit	lical		d			1					_		
Box 68 leath certifical attending phy for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancv	-			22d Day	to of dolly any	wn		
P.O. Box at the death cer if by the attendin stached for use	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Feta	I death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су			te of delivery onth Day Year			
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Rec ne law e has ge 2 s	I d							pe	topsy rformed?	Were autopsy findings available prior to completion of cause of death?			
tal an: Ti tifficate tor, pa		25. Was case referred to med	ical				26. Place	1 ☐ Yes of Death (Check only	1	1 ☐ Yes 2 ☐ No	_		
f Vinysicia	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	nt 3 🗆 DOA Oti	hor:		ng Home 5 ☐ Residence 6 ☐ Other (Specify)				
on of Vital Reding Physician: The Inf. After this certificate here	L:no	27. Manner of Death 1 ✓ Natural 5 ☐ Per	28a. Date of Injuding (Month, Da	ury ay, Year)	28b. Time o Injury	Wo			e how injury occurr	red			
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signe in by the funeral director, page 2 should be do in by the funeral director, page 2 should be do	icati	2 Accident investigation M 1 Yes 2 No					2007	206 Legation (Charles and Marchan & David Roots Marchan					
	Certification: To	4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Golden Homicide 4 ☐ Homicide 5 ☐ Homicide 4 ☐ Homicide 5 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 7 ☐ Homicide 8 ☐ Homicide 8 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 2 ☐ Homicide 2 ☐ Homicide 2 ☐ Homicide 3 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Homicide 5 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 7 ☐ Homicide 8 ☐ Homicide 8 ☐ Homicide 8 ☐ Homicide 1 ☐ Homicide 8 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 1 ☐ Homicide 2 ☐ Homicide 2 ☐ Homicide 3 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Homicide 4 ☐ Homicide 5 ☐ Homicide 5 ☐ Homicide 5 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 6 ☐ Homicide 7 ☐ Homicide 8 ☐ Homi						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C	29a. Certifier T Certi (Check only 2 Medicone)	fying Physician: To the best cal Examiner: On the basis of and manner st	of examina	owledge, deat ation and/or in	th occurred at the to estigation, in my	time, date and opinion, deat	I place, and due to the occurred at the time	he cause(s) and ma e, date and place,	anner as stated. and due to the cause(s)	_		
To the within 2 To the comple	Mec	29b. Signature and title of cert				29c. Licen	se number		29d. Date signe	d (Month, Day, Year)	_		
		1 lutur Pm	Yaumuch	MI)	P00	520	22	April 2	0 2009			
\		30. Name and address of pers	on who completed cause of	death (Iter	n 23a) (Type,	Print)					_		
-		Kohert M	Yayayah 1	rar's shine	tureb as a	9					_		
S Regis	tate trar	31. Date filed APR 23 2	UU9 Centra	Sile	turpare								

DHMH 17 Rev 1/2001

		For State	State of	of Marylan	•	rtment of F		,		2000	12000
		Registrar 1. Decedent's Name (First, Middle, L				uncale of t	2. Date of De	Reg. No.	2003	3. Time of Death	
Physicia /Medic		EMILY	E	1	YAN			APRIL	/9	2009	9:45 AM
Examin		4a. Facility Name (If not institution, g		mber) HLTH	REH	4b. City, Town, or GLE	r Location of Death	RNIE		County of Death	DEL
Funeral Director			Sex 1□M 2AF	7. Age (In yrs. 87	last birthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 4	th ay, Year) ,1921	9. Birthp Coun	place (State or Foreign htry)
pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Loc	cation				1	Od. Inside City Limits
/anyla	ō	MD Anne A	runde1		Linthi						1 □ Yes 2X No
r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Coun	ntry?
th with		422 Hawthrone Re	oad			21090			U.S	.A.	
er dea items	Funeral	11. Marital Status	Armed F	edent Ever in U. orces?	S. 13. y	Vas Decedent of H FYes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14	 Race - Americ Black, White, e 	
urs aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, G Year or D	ive	1	□Yes 2 No	Specify:		S	Specify: Whi	lte
72 hou	eted	15. Decedent's (Specify only highest of	nest arade completed) (Give kind of work done during most of working					king	16b. Kind	d of Business/Inc	dustry
within ene.	Completed	Elementary/Secondary (0-12)	ilementary/Secondary (0-12) College (1-4or 5+)				,				
filed I Hygin	Be Co	17. Father's Name (First, Middle, La.	st)		Homen	aker	18. Mother's Nam	ne (First, Middle		urname)	
uld be Menta Arked	To B	Lester Orrison					Bertha				
2 sho 2 sho 1 and l		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,									
1 and 1 and Health em 27		Mr. Cary V. Hann	/Son	20b. F		Cayer Dr				nie, MD ation - City or To	
ages ent of nt: If It		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				sition (Name of natory or other plac en Mem.Pa		L 24,	G1	Len Burn	nie, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If the X7 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Evantiant must be notified at other.		21. Signature Funeral Service Lice	ensee	1220	22	. Name and Addres	ss of Facility S11	_			
		23a. Part 1. Enter the disease, or co	mplications that	caused the deatl							Approximate Interval Between
Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	Co.	SPIR	ATIC	DN I	PNEU	MONI	A		Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):						
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uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		RONIC	AT	RIAL ,	FIBRIL	LATI	DN		
icate be executed physician and the burial-transit		resulting in death) Last	U	(or as a consequ	uence of):						
ficate physics the b	edical		d								
eath certific	M/u	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc			23	3d. Date of delive	•
The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ≥ No 9 □ Unknown		gnant at time of c		Other (specify)	у			Month	Day Year
that the ned by detac		Part II. Other significant conditions	contributing to c	leath but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did 1	tobacco use	e contribute to the	he cause of death?
w requires been sign should be	ed by							1 🗆	Yes 2□	No 3□ Prob	bably 4 nknown
law re las be	Completed							24a. Was	psy /	prior to cor	opsy findings available ompletion of cause of
	Co							perfo 1 □ Yes	2 No	death? 1 □ Yes	2 🗆 No
sician: certific irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 2 No									
Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
eath. or: After the funer	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	ion			M 1 🗆	Yes 2□No				
Direct	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place build	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28f. Location (City or To	Street and i wn, State)	Number or Rura	al Route Number,
spital hours meral y filled		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
the Hospital hin 24 hours the Funeral mpletely filled	Medical	onė)	and mar	nner stated.		-					
5 with 6 con con con con con con con con con con	2	29b. Signature and title of certifier	1-Celo	torre	1	29c. Licens	e number	1	29d. Date:	signed (Month,	Day, Year)
		30. Name and address of person wh	o completed cau	se of death (Item	n 23a) (Type. F	Print) 1/4	LFRIII	CFQ	OTA	P 1 1	n. D
(e V		7445 FUK	LNACE	BK	PANC	HR	D, 64	EN B	URN	ITE, M	Day, Year) 2009 M. D. 7 D. 21060
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea Virginia Elizabeth Hartman 2009 April 07:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore Co. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 215-09-8393 93 March 13,1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Co. <u>Parkville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8834 Walther Blvd. Apt109 21234 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2x ☐ No Specify. Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 yrs. <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fred Wagner Bertha Edna Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Martha Hartman West /Daughter 1731 Wentworth Avenue Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Chester Springs, PA 4 ☐ Donation 5 ☐ Other (Specify) Peter Luth. Cem. 04/24/2009 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01121 Services PA, 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE DenenTil disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any Lenter Underlying cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an autops, performed 1 ∐Yes 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

> burial-transi and

attending physician for use as the buria

detached

director, page 2 should

Be

Certification: To

cal

certificate

this funeral

After

after death

To the Hospital or within 24 hours at To the Funeral D

filled in by

completely

signed I

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

or items,

"natural"

perr it. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Imp. rtant: if item 27 is marked other than "any injury or other traumatic event, it is Magnotic.

the Medical Examinant rust be notified at

Director

Funeral

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Completed

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Maryland 21215-0036

Baltimore,

Examine

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown \$ Completed

2 Accident

(Check only

3 Suicide

29a. Certifier

25. Was case referred to medical examiner's 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural

5 Pending investigation 6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8800

28b. Time of

1 ☐Yes 2 ☐No

28c. Injury at Work?

29c. License number MD

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ROG7343

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNA

BRAZICA ALKE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

WALTHER Blud

PARKVIILE, UD 21234

LOUN 20, 2009

Registrar DHMH 17 Rev 1/2001

State